NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council or the Attorney General. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 6. ECONOMIC SECURITY

CHAPTER 5. DEPARTMENT OF ECONOMIC SECURITY SOCIAL SERVICES

Editor's Note: The following Notice of Final Rulemaking was reviewed per Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 2757.) The Governor's Office authorized the notice to proceed through the rulemaking process on January 20, 2012.

[R12-202]

PREAMBLE

1. Article, Part, or Sections Affected — **Rulemaking Action**

Article 56	Amend
R6-5-5601	Amend
R6-5-5602	Amend
R6-5-5603	Amend
R6-5-5604	Amend
R6-5-5605	Amend
R6-5-5606	Repeal
R6-5-5606	Renumber
R6-5-5606	Amend
R6-5-5607	Renumber
R6-5-5607	Amend
R6-5-5608	Renumber
R6-5-5608	Amend
R6-5-5609	Renumber
R6-5-5609	Amend
R6-5-5610	Renumber
R6-5-5610	Amend
R6-5-5611	Repeal
R6-5-5612	Renumber

2. Citations to the agency's statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. § 41-1954(A)(3)

Implementing statute: A.R.S. § 8-807

3. The effective date of the rules:

December 2, 2012

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable

4. Citations to all related notices published in the *Register* to include the *Register* as specified in R1-1-409(A) that per-

tain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 17 A.A.R. 1305, July 15, 2011

Notice of Proposed Rulemaking: 18 A.A.R. 726, March 23, 2012

5. The agency's contact person who can answer questions about the rulemaking:

Name:	Beth Broeker
Address:	Department of Economic Security P.O. Box 6123, Site Code 837A Phoenix, AZ 85005 or Department of Economic Security 1789 W. Jefferson, Site Code 837A Phoenix, AZ 85007
Telephone:	(602) 542-6555
Fax:	(602) 542-6000
E-mail:	bbroeker@azdes.gov
Web site:	http://www.azdes.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

This rulemaking will amend the rules related to the request and release of Child Protective Services information. It will also amend the rules associated with the fees for the copying of the requested materials. This will ensure compliance with A.R.S. § 8-807.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

None

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. A summary of the economic, small business, and consumer impact:

There is minimal small business or consumer impact. The majority of requests for CPS information involve a request for a redacted copy of the CPS report. From January 1, 2011 to December 31, 2011, the Child Abuse Hotline received 1,054 requests for redacted CPS reports from individuals about whom the report was made. The Department of Economic Security does not charge a copying fee for the release of redacted CPS reports.

A person who is a participant in a CPS case may request CPS information about himself or herself. The Department of Economic Security redacts information about other case participants before releasing the information to the person requesting the information. From January 1, 2011 to December 31, 2011, the Department received approximately 311 requests for CPS information from case participants. The Department does not charge a copying fee for the release of redacted CPS information to case participants.

The Department also does not charge a copying fee for requests for CPS information from a client or an attorney representing the client in a dependency, guardianship, termination of parental rights, or other court proceeding. From January 1, 2011 to December 31, 2011, the Department received approximately 583 of these requests.

Pursuant to A.R.S. §§ 8-807 and 39-121.03, the Department may charge a copying fee for public records requests for CPS information. These requests are usually made by the media, law firms representing clients, and individuals seeking contract-related information. From January 1, 2011 to December 31, 2011, the Department received 114 public records requests for CPS information. The Department's copying fees for public records requests are $1.00 for the first page; $.25 for each additional page; and $10.00 per CD/DVD if the CPS information already exists in an electronic format or $10.00 per CD/DVD plus the actual cost to convert the CPS information to an electronic format if the information does not already exists in an electronic format.

The Department has received less than ten public records requests where the requester paid per page for copying cost. The average size of these requests was six pages or $2.25 in copying cost. Due to the cost savings to the small business or consumer, the majority of public records requesters pay the cost to copy the CPS information to an electronic format.

The Department has not made any substantial changes since the Notice of Proposed Rulemaking was published on March 23, 2012, other than minor clarifying typographical and formatting changes that were made at the recommendation of Council staff.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department has not made any substantial changes since the Notice of Proposed Rulemaking was published on March 23, 2012, other than minor clarifying typographical and formatting changes that were made at the recommendation of Council staff.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

None

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

Not applicable

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

None

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

None

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:

None

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable

15. The full text of the rules follows:

TITLE 6. ECONOMIC SECURITY

CHAPTER 5. DEPARTMENT OF ECONOMIC SECURITY SOCIAL SERVICES

ARTICLE 56. CONFIDENTIALITY AND RELEASE OF CPS ~~RECORDS~~ INFORMATION

Sections

R6-5-5612. Renumbered

ARTICLE 56. CONFIDENTIALITY AND RELEASE OF CPS ~~RECORDS~~ INFORMATION

R6-5-5601. Definitions

The definitions contained in A.R.S. §§ 8-531, 8-201, ~~8-807~~ 8-801, R6-5-5501, and the following definitions apply in this Article:

~~1. "ACYF" means the Administration for Children, Youth and Families, an organizational unit within the Division of Children, Youth and Families, Department of Economic Security.~~

1. "Abuse" means the same as in A.R.S. § 8-201(2).

2. "CASA" or "Court Appointed Special Advocate" means a person appointed under A.R.S. § 8-522.

~~2~~.3. No change

~~3~~.4. "Completed request" means a ~~Request for Confidential Information~~ written communication to the program or a form provided by the Department asking for CPS information with all information filled in ~~completed as prescribed in R6-5-5603~~.

5. "Copying fee" means the final amount a requester is required to pay to the Department before the Department releases the requested CPS information.

~~4~~.6. "CPS" means Child Protective Services, a program within the ~~Administration for~~ Division of Children, Youth and Families (~~ACYF~~ DCYF) to receive and investigate allegations of child ~~maltreatment~~ abuse and neglect and provide protective services as described in ~~R6-5-5501(40)~~ A.R.S. § 8-801(4).

~~5. "CPS Administrator" means the DES Administrator responsible for the operation of CPS, or that person's designee, which may include the ACYF Field Operations Manager, the CPS District Program Manager ("DPM"), the CPS Assistant District Program Manager ("APM") or the CPS Local Office Manager.~~

7. "CPS Information" means the same as in A.R.S. § 8-807(U)(1) and includes information contained in a hard copy or electronic case record, and both oral and written information.

8. "DCYF" means the Division of Children, Youth and Families within the Department of Economic Security.

~~6~~.9. No change

~~7~~.10. "Estimated ~~processing~~ copying fee" means an amount a requester ~~must~~ is required to pay to the Department before the Department copies and redacts requested CPS information ~~records and files~~.

11. "FCRB" means the Foster Care Review Board established pursuant to A.R.S. § 8-515.01.

~~8. "Information" means data contained in a hard copy case file or electronic case record.~~

~~9. "Maltreatment" means alleged abuse, neglect, abandonment, or exploitation of a child.~~

12. "Neglect" means the same as in A.R.S. § 8-201(22).

13. "Person that provides oversight" means those individuals, entities, or bodies described in A.R.S. § 8-807(H) and any other individual, entity or body as authorized by law.

~~10.~~14. "Person ~~about whom a report is made~~ who is the subject of CPS information" means ~~an alleged abusive~~ a caregiver, child or other person identified in the CPS report~~, or a child victim age 12 or older~~.

~~11.~~15. "Personally identifiable information" means information ~~which~~ that specifically identifies a protected individual and includes:

a. No change

b. Date of Birth;

~~b.~~c. ~~Address~~ Street address;

~~c.~~d. Telephone~~, or~~ fax number, or email address;

~~d.~~e. No change

~~e.~~f. No change

~~f.~~g. No change

~~g.~~h. No change

~~h.~~i. No change

~~i.~~j. No change

~~j.~~k. No change

~~k.~~l. No change

~~l.~~m. No change

~~m.~~ n.Any other information that would permit another person to readily identify the subject of the CPS information.

~~12. "Processing fee" means the final amount a requester must pay to the Department for copying and redacting requested records and files, before the Department will release the copied records and files.~~

~~13.~~16. "Protected individual" means a living person who is the subject of a CPS investigation and includes:

a. No change
b. No change
c. No change
d. No change
e. No change
f. The person who made the report of child ~~maltreatment~~ abuse or neglect, and
g. Any person whose ~~health~~ life or safety would be endangered by disclosure of CPS information.

~~14.~~17. "Redacting" means striking or blacking out personally identifiable information contained in CPS hard copy or electronic case records ~~or files~~ on protected individuals so that no one can read the information.

18. "Report" means an incoming communication containing an allegation that:

a. A child is the subject of abuse or neglect;
b. A parent, guardian or custodian inflicted, may inflict, permitted another person to inflict, or had reason to know another person may inflict such abuse or neglect; and
c. Contains sufficient information to locate the child.

19. "Request" means a written communication for CPS information.

~~15.~~20. "Requester" means an individual, entity, or ~~organization~~ body that has made a ~~public records~~ request for CPS information ~~from a CPS record or file~~.

~~16.~~21. No change

~~17.~~22. "Workday" means Monday through Friday excluding Arizona state holidays and mandatory furlough days.

R6-5-5602. Scope and Application

A. This Article governs ~~public records~~ requests for and release of CPS information ~~and all requests~~ made under A.R.S. § 8-807.

~~**B.** The Department shall handle any request or subpoena for information made by a party to a pending administrative proceeding, or civil, criminal, juvenile, probate, or domestic relations court proceeding, in accordance with the disclosure and discovery rules applicable to the particular proceeding or court.~~

B. CPS maintains information in accordance with federal laws under A.R.S. § 8-807.

R6-5-5603. Procedures for Requesting CPS Information

A. A person who wishes to obtain CPS information ~~pursuant to~~ under A.R.S. § 8-807 shall comply with the requirements of this Section, and any applicable limitations and conditions in R6-5-5605~~,~~ and R6-5-5607~~, R6-5-5608, and R6-5-5609~~.

1. This Section does not apply to a person or entity entitled to receive CPS information to:
   a. Meet its duties to provide for the safety, permanency, and well-being of a child;
   b. Provide services to the child or family to strengthen the family;
   c. Enforce or prosecute violations of child abuse or neglect laws; or
   d. Provide CPS information to a defendant as required by an order of the criminal court.
2. This Section also does not apply to juvenile, domestic relations, family or conciliation courts, the parties or their attorneys in a dependency, guardianship, or termination of parental rights proceeding, the FCRB, a CASA, or a person that provides oversight.

B. The requester shall send the Department a completed ~~information~~ written request or use the form~~, as~~ provided ~~in subsections (C) and (D)~~ by the Department. The request ~~form~~ shall include the following information:

1. No change
~~2. Name and title of the person signing the form;~~
~~3.~~2. No change
   a. No change
   b. No change
   c. No change
   d. No change
~~4.~~3. Any other data that the requester believes will be likely to assist the Department in identifying the CPS information requested, such as ~~including the following~~:
   a. The name of the child's siblings;

b. The child's ~~social security~~ Social Security number;
c. The name of the CPS Specialist handling the case; and
d. The location of the alleged ~~maltreatment~~ abuse or neglect~~;~~.

~~5. A description of the specific information needed;~~
~~6. A statement of purpose for which the information is needed;~~
~~7. The notarized signature of the requester, unless the information is released pursuant to a court order; and~~
~~8. The address to which the requested information is to be mailed, or an indication of another method for handling the response.~~

~~**C.** The requester shall send the request to a local Department office or to the address indicated on the form.~~

C. Before releasing CPS information under this Section, the Department shall determine that the person or entity requesting the CPS information is a person or entity entitled to receive the CPS information under this Article and A.R.S. § 8-807.

~~**D.** A person seeking information pursuant to A.R.S. §8-807(C)(10), (D), or (F), shall also send the Department a processing fee in an amount determined under R6-5-5612.~~

R6-5-5604. Procedures for Processing a Request for CPS Information

A. Upon receipt of a request for CPS information, the Department shall determine whether the request is complete. If the request is incomplete, the Department shall either:
1. Return the ~~form~~ request to the requester with a statement explaining the additional information the Department needs to process the request; or
2. Contact the requester to obtain the missing information.

B. Upon receipt of a completed request, the Department shall stamp the receipt date on the ~~form~~ request. The receipt date is the day ~~that~~ the Department ~~receiving office designated on the form actually~~ receives the completed request.

C. Within 30 ~~days~~ workdays of the receipt date, the Department shall provide the requester with one of the following written responses:
1. A statement that the requested CPS information does not exist;
2. The requested CPS information;
3. A statement that the Department cannot provide the requested CPS information within 30 ~~days~~ workdays, the reason for the delay, and the anticipated time-frame for response; or
4. A statement that the Department cannot ~~legally~~ release the requested CPS information, with the statutory citation and the reason for the denial.

R6-5-5605. ~~Release of Information in Situations Requiring Immediate Action or Service to a Child~~ Procedures for Processing a Request for CPS Information from a Person or Entity Providing Services in Official Capacity

A. The Department shall release CPS information without obtaining the fee required by R6-5-5610 ~~When~~ when a person or entity entitled to receive ~~records under A.R.S. § 8-807(C)~~ CPS information requires information to: ~~from a record or file in order to take immediate action on behalf of, or render service to, a child who is or may be the victim of maltreatment, the Department shall release the information without obtaining the form or fee required by R6-5-5603.~~
1. Meet its duties to provide for the safety, permanency, and well-being of a child;
2. Provide services to the child or family to strengthen the family;
3. Enforce or prosecute a violation of child abuse or neglect laws;
4. Provide CPS information to a defendant as required by an order of the criminal court; or
5. Provide CPS information to:
   a. A juvenile, domestic relations, family or conciliation court;
   b. The parties or their attorneys in a dependency, guardianship, or termination of parental rights proceeding;
   c. The FCRB;
   d. A CASA; or
   e. A person that provides oversight.

B. Before releasing CPS information under ~~pursuant to~~ this Section, the Department shall ~~verify~~ determine that the person requesting CPS information is a person entitled to receive CPS information under ~~A.R.S. § 8-807(C)~~ this Section and A.R.S. § 8-807.

~~**C.** The Department shall:~~
~~1. Obtain the name and telephone number of the requester;~~
~~2. Call the requester to verify:~~
~~a. That the person requesting information is a person entitled to receive information under A.R.S. §8-807(C); and~~
~~b. That the requester needs the information for a purpose described in subsection (A).~~

~~**R-6-5-5606. Release of Report and Investigation Findings**~~

~~**A.** Under A.R.S. §8-807(E), a person about whom a report is made who is not a party in a dependency or termination of parental rights proceeding may obtain a copy of a CPS report and investigation findings, including the following persons:~~
~~1. An adult about whom a CPS report has been made;~~

~~2. A child victim age 12 or older;~~
~~3. A child's parent or legal guardian.~~

~~**B.** The person requesting a copy of the CPS report and investigation findings shall submit a completed information request form which shall include the information listed in R-5-5603(B). Within 30 days of receipt of a completed information form, the Department shall provide the requester with either;~~
~~1. A copy of the report and investigation findings, after redacting information as required by A.R.S. §8-807(E) and (G); or~~
~~2. A written response indicating that the Department does not have the requested report or investigation findings.~~

~~R6-5-5607.~~R6-5-5606. Release of Summary CPS Information to a Person Who Reported Suspected Child Abuse and Neglect

A. A person who reports alleged child ~~maltreatment~~ abuse or neglect to CPS may contact CPS to ~~determine the outcome of the report as permitted under A.R.S. §8-807(H)~~ obtain a summary of the outcome of the investigation, as permitted by A.R.S. § 8-807.

B. After receiving a request and before releasing CPS information, the Department shall ~~verify~~ determine that the person requesting CPS information was the person who made the report as follows:
1. Obtain the name and telephone number of the requester~~;~~, and
2. Compare the requester's name with the name of the person listed as the reporting source ~~reporter~~ on the CPS report.~~; and~~
~~3. Call the requester and advise whether the Department can legally honor the request.~~

~~**C.** After verifying the identity of the requester, CPS shall give the person a summary of the outcome with the following information:~~
~~1. Disposition of the report;~~
~~2. Investigation findings, if available; and~~
~~3. A general description of the services offered or provided to the child and family.~~

C. After determining the identity of the requester, the Department shall call and advise the requester whether the Department has statutory authority to provide the requested CPS information.

D. If the requester is entitled to receive the requested CPS information, CPS shall verbally provide the person a summary of the outcome with the following CPS information:
1. Disposition of the report;
2. Investigation findings, if available; and
3. A general description of the services offered or provided to the child and family.

~~R6-5-5608.~~ R6-5-5607. Release of CPS Information for ~~to~~ a Research or Evaluation Project

A. A person seeking CPS information for a research or evaluation project shall send a written request to the Department ~~and provide information required for a complete request, under R6-5-5603~~. A ~~complete research~~ request shall ~~also~~ include the following information:
1. If the person works for a research organization:
   a. The name of the organization, and
   b. The organization's mission;~~,~~
2. A description of the research or evaluation project, ~~and~~ which explains how the results of the project will improve the child protection system;
3. A description of the plan for maintaining the confidentiality of personally identifiable information and disseminating the results of the project; and
~~3~~4. No change

B. ~~Upon~~ Within 30 workdays of receipt of a completed request from a research requester, the Department shall ~~advise~~:
1. Advise the requester whether the Department will ~~can legally honor the request~~ provide the requested CPS information, ~~and~~
2. Inform the requester of the estimated ~~amount of the processing~~ copying fee required under ~~R6-5-5612~~ R6-5-5610, and
3. Inform the requester of the expected time-frame for providing the requested CPS information.

C. Upon receipt of the ~~processing~~ copying fee, the Department shall provide the requester with ~~the expected time-frame for releasing~~ the requested CPS information.

~~R6-5-5609.~~R6-5-5608. Release of CPS Information to a ~~Legislative Committee~~ Legislator or Another Person that Provides Oversight

~~**A.** A legislative committee entitled to receive information under A.R.S. § 8-807(C)(12), shall send a written request for information to the Department Director, or the Director's designee.~~

~~**B.** The written request shall include:~~
~~1. The name of the committee,~~
~~2. The purpose for which the information is sought; and~~

~~3. The date by which the committee needs the information.~~

~~**C.** The Department Director, or the Director's designee, shall evaluate all requests for information and determine whether to release information to a legislative committee.~~

~~**D.** When releasing information to a legislative committee, the Department shall send the committee written notice that the information is confidential and shall not be further disclosed.~~

A. A person that provides oversight of child protective services and seeks CPS information shall send a written request to the Department and include the following information:

1. The name of the person seeking the information;
2. The purpose of the request and its relationship to the person's official duties; and
3. The person's signature, or the signature of an authorized agent for an entity or other body, confirming that the person or authorized agent understands the CPS information shall not be further disclosed unless authorized by A.R.S. § 8-807.

B. A legislator or committee of the legislature seeking CPS information to perform official duties shall send a written request to the presiding officer of the body of which the state legislator is a member and include the name of the person whose case record is to be reviewed and any other information that will assist the Department in locating the record. The legislator shall also sign the request, confirming that the legislator understands that the CPS information shall not be further disclosed unless authorized by A.R.S. § 8-807. The presiding officer shall forward the request to the Department within five workdays of receiving the request.

C. The copying fee required under R6-5-5610 does not apply to this Section.

D. Within 10 workdays of receiving the request, the Department shall provide the requester with one of the following written responses:

1. A statement that the requested CPS information does not exist;
2. The requested CPS information;
3. A statement that the Department cannot provide the requested CPS information within 10 workdays, the reason for the delay and the anticipated time-frame for response; or
4. A statement that the Department cannot provide the requested CPS information, with the statutory citation and the reason for denial.

~~R6-5-5610.~~R6-5-5609. Release of CPS Information ~~to a State Official~~ in a Case of Child Abuse, Abandonment, or Neglect that has Resulted in a Fatality or Near Fatality

~~**A.** An Arizona state official entitled to receive information under A.R.S. §8-807(C)(15) shall send a written request to the Department Director.~~

~~**B.** The Director or the Director's designee, shall verify:~~

~~1. That the requesting state official is:~~
~~a. Responsible for administration of CPS; or~~
~~b. Responsible for oversight of CPS enabling or appropriating legislation; and~~
~~2. That the requesting state official is seeking the information to carry out official functions.~~

A. A person who requests CPS information under A.R.S. § 8-807 concerning a case of child abuse, abandonment, or neglect that resulted in a fatality or near fatality, shall send a written request to the Department.

B. Upon receipt of the request, the Department shall stamp the receipt date on the request and begin gathering the requested CPS information.

C. The Department shall notify the requester in writing of the estimated copying fee. If the requester does not want to proceed, the requester shall notify the Department within 72 hours to cancel the request. If this notification is oral, the requester shall confirm the cancellation in writing.

D. The requester shall pay the estimated copying fee before the Department copies any CPS information.

E. After receipt of the final copying fee, the Department shall provide CPS information consistent with A.R.S. § 8-807.

~~R6-5-5612.~~R6-5-5610. Fees

~~**A.** If a record production will result in a processing fee, the Department shall notify the requester of the estimated processing fee before copying any records. Within 10 days of the date of the estimate, the requester shall send the fee or advise the Department to terminate the request.~~

~~**B.** When providing information to the persons entitled to receive information under A.R.S. § 8-807(C)(10), (D), or (F), the Department shall charge a fee of 25¢ per page.~~

~~**C.** The fee per page covers the partial cost of:~~

~~1. Staff time to research and collect the requested information;~~
~~2. Staff time to review and redact information pursuant to A.R.S. § 8-807(D), (F), and (G);~~
~~3. Administrative staff time to review and prepare the information to be submitted; and~~
~~4. Costs of copying supplies such as paper, toner and use of equipment.~~

~~**D.** The fee per page applies to both persons who obtain copies of files and persons who request to review files that must be redacted prior to review, under A.R.S. §8-807(C)(10), (D), or (F).~~

~~**E.** After the Department has prepared information for release, the Department shall prepare an itemized billing statement showing the document preparation costs and the fees the requester must pay before the Department can release the records and files.~~
~~**F.** The Department shall refund any prepaid estimated processing fees that exceed the final processing fee.~~
A. If the Department determines a request for CPS information will result in a copying fee, the Department shall notify the requester of the estimated fee before copying any CPS information.
B. Unless otherwise exempted by this Chapter, the Department shall charge a copying fee at the current rate set by the Department, as provided on the DES website at http://www.azdes.gov.
C. The copying fee applies to both paper and electronic copies. If the CPS information does not already exist in an electronic format, additional fees that reflect the actual cost of conversion will apply to copy the CPS information to an electronic format.
D. The Department shall notify the requester in writing of the final copying fee.
E. The Department shall reimburse the requester if final copying costs are less than the estimated copying fee.

R6-5-5611. ~~Release of Information to a Person Who Requests Records and Files Concerning an Alleged Victim of Abuse, Neglect or Abandonment Who Has Died~~ Repealed

~~**A.** An individual who requests records and files under A.R.S. §8-807(C)(13), concerning an alleged victim of abuse, neglect or abandonment who has died, shall send the Department a completed request on each child.~~
~~**B.** Upon receipt of the request form the Department shall stamp the date and time of receipt and complete a record and location search.~~
~~**C.** The Department shall notify the requester in writing of the estimated processing fee required under R6-5-5612. If the requester does not want to proceed, the requester shall send the Department written notice to cancel the search.~~
~~**D.** Upon receipt of a cancellation notice, the Department shall return the estimated processing fee.~~
~~**E.** Upon receipt of the estimated processing fee, the Department shall prepare the records and files within 30 work days from receipt of the estimated processing fee and notify the requester of the final processing fee for records and file preparation.~~
~~**F.** After receipt of the final processing fee, the Department shall notify the requester and send the redacted records and files as indicated on the original request.~~

R6-5-5612. Renumbered

NOTICE OF FINAL RULEMAKING

TITLE 6. ECONOMIC SECURITY

CHAPTER 8. DEPARTMENT OF ECONOMIC SECURITY
AGING AND ADULT ADMINISTRATION

Editor's Note: The following Notice of Final Rulemaking was reviewed per Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 2757.) The Governor's Office authorized the notice to proceed through the rulemaking process on October 3, 2011.

[R12-201]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R6-8-201	Amend
R6-8-204	Amend
R6-8-205	Amend
R6-8-206	Amend
R6-8-210	Amend

2. Citations to the agency's statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):

Authorizing statutes: A.R.S. § 41-1954

Implementing statutes: A.R.S. §§ 46-451 through 46-459

3. The effective date of the rules:

December 2, 2012

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable

4. Citations to all related notices published in the *Register* to include the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 18 A.A.R. 633, March 9, 2012

Notice of Proposed Rulemaking: 18 A.A.R. 836, April 6, 2012

5. The agency's contact person who can answer questions about the rulemaking:

Name:	Beth Broeker
Address:	Department of Economic Security P.O. Box 6123, Site Code 837A Phoenix, AZ 85005 or Department of Economic Security 1789 W. Jefferson, Site Code 837A Phoenix, AZ 85007
Telephone:	(602) 542-6555
Fax:	(602) 542-6000
E-mail:	bbroeker@azdes.gov
Web site:	http://www.azdes.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Arizona Department of Economic Security administers the state Adult Protective Services program under the Arizona Revised Statutes, Title 46, Chapter 4, and investigated 6,889 clients in State Fiscal Year (SFY) 2011.

Since the last rule revision the Adult Protective Services program has undergone changes due to legislation and changes in the Department's policy and procedures. To reflect those changes, the Department, through this rulemaking, will:

- Remove subsection R6-8-201(13)(n), APS worker narrative, from the definition of "Personally identifiable information."
- Clarify subsection R6-8-204(A) and add subsection R6-8-204(B) to specify that the APS worker shall investigate reports that occurred on an Indian reservation, upon written invitation by the tribal council.
- Change subsection R6-8-206(3) to more accurately reflect the appropriate response time to cases, depending on the priority levels.
- Delete subsection R6-8-206(B).
- Amend subsection R6-8-210(B) to change the location where a person sends a request to obtain personally identifiable information.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

None

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. A summary of the economic, small business, and consumer impact:

The rulemaking itself will have no cost effect on employers, claimants, or the Department. The rulemaking will not adversely affect any legitimate business. The rulemaking will have no impact on state revenues.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department has not made any substantial changes since the Notice of Proposed Rulemaking was published on April 6, 2012, other than minor clarifying typographical and formatting changes that were made at the recommendation of Council staff.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response

to the comments:
None

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:
Not applicable

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:
These rules do not require a permit.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:
Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:
No analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:
None

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:
Not applicable

15. The full text of the rules follows:

TITLE 6. ECONOMIC SECURITY

CHAPTER 8. DEPARTMENT OF ECONOMIC SECURITY AGING AND ADULT ADMINISTRATION

ARTICLE 2. ADULT PROTECTIVE SERVICES

Sections
R6-8-201. Definitions
R6-8-204. Jurisdiction
R6-8-205. Classification
R6-8-206. Investigation
R6-8-210. Confidentiality

ARTICLE 2. ADULT PROTECTIVE SERVICES

R6-8-201. Definitions
No change
1. No change
2. No change
3. No change
4. No change
   a. No change
   b. No change
5. No change
6. No change
7. No change
8. No change
9. No change
10. No change
11. No change
12. No change
    a. No change
    b. No change

c. No change
13. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change
    f. No change
    g. No change
    h. No change
    i. No change
    j. No change
    k. No change
    l. No change
    m. No change
    n. ~~APS worker narrative~~ Medical information, history, and diagnosis; or
    o. Any other ~~identifier specific to an individual~~ information that would reasonably lead to the identification of a person.
14. No change
15. No change
16. No change
17. No change
18. No change
19. No change
20. "~~Work~~ Business day" means ~~8~~ 8:00 a.m. to ~~5~~ 5:00 p.m., Monday through Friday, excluding Arizona state holidays.

R6-8-204. Jurisdiction

A. An APS worker shall not investigate reports of events ~~which~~ that occurred in another state~~,~~ or foreign country~~, or Indian reservation~~.

~~**B.** When the Department receives a report of alleged abuse, neglect, or exploitation of a person who is outside of the jurisdiction, the Department shall make a report to the appropriate state, international, or tribal government or social services agency.~~

B. An APS worker shall investigate reports that occurred on an Indian reservation, upon written invitation by the tribal council.

R6-8-205. Classification

At intake, an APS worker shall classify the incoming communication into ~~1~~ one of the following ~~3~~ two categories:
1. Information and referral~~;~~, or
2. Report accepted for evaluation and investigation~~; or,~~
3. ~~Report accepted for evaluation, but not investigation~~.

R6-8-206. Investigation

~~**A.**~~ Reports Accepted for Evaluation and Investigation:
1. No change
    a. No change
    b. No change
    c. No change
2. No change
3. An APS worker shall visit a person who may be in need of adult protective services within ~~2 work days after receipt of a report.~~ the following established time-frames:
    a. Priority 1. The APS worker shall initiate an assessment within one business day following a report of a qualifying problem with an imminent and substantial risk of life-threatening harm.
    b. Priority 2. The APS worker shall initiate an assessment within two business days following a report of a qualifying problem with aggravating circumstances.
    c. Priority 3. The APS worker shall initiate assessment within five business days following a report of a qualifying problem with mitigating or no aggravating circumstances.
4. The APS worker shall investigate, determine, and document in the record whether:
    a. The allegations are ~~substantiated~~ proposed for substantiation,
    b. No change
    c. No change
    d. No change

e. No change
f. No change
5. No change
a. No change
b. No change
c. No change
d. No change
e. No change
f. No change
g. No change
h. No change
i. No change
j. No change
k. No change
l. No change
m. No change
n. No change
o. No change
p. No change
i. No change
ii. No change
iii. No change
iv. No change
v. No change

~~**B.** Reports Accepted for Evaluation but not investigation. APS may classify a report as not accepted for investigation because of:~~
~~1. Insufficient information,~~
~~2. Sufficient involvement of other resources,~~
~~3. The situation is known to APS and the report does not provide additional information, or~~
~~4. The client's need is for placement into a care facility only.~~

R6-8-210. Confidentiality

A. No change
B. The ~~requester~~ person shall send a written request to the ~~APS program manager for the office where the requester believes the records are located; the~~ Custodian of Records at the Department of Economic Security, Division of Aging and Adult Services, Adult Protective Services, Central Office, 1789 W. Jefferson, Site code 950A, Phoenix, Arizona 85007. The request shall include the following information:
1. No change
2. No change
3. No change
4. No change
5. No change
a. No change
b. No change
c. No change
C. No change
D. No change
E. The Department shall respond to the requester within 15 ~~work~~ business days.
F. No change
1. No change
2. No change
3. No change

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

Editor's Note: The following Notice of Final Rulemaking was reviewed per Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 2757.) The Governor's Office authorized the notice to proceed through the rulemaking process on September 19, 2011.

[R12-203]

PREAMBLE

1. Article, Part, or Section Affected (as applicable) | **Rulemaking Action**

Article 23	New Article
R20-6-2301	New Section
R20-6-2302	New Section
R20-6-2303	New Section
R20-6-2304	New Section
R20-6-2305	New Section

2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):

Authorizing statutes: A.R.S. §§ 20-142 and 20-143(A)

Implementing statutes: A.R.S. §§ 20-1342.02 and 20-1054(A)(2)

3. The effective date for the rules:

October 3, 2012

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

When filed with the Secretary of State under A.R.S. § 41-1032(A)(3) to comply with deadlines in amendments to a federal program.

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the proposed rule:

Notices of Rulemaking Docket Opening: 17 A.A.R. 2103, October 21, 2011

Notice of Formal Rulemaking Advisory Committee: 17 A.A.R. 2388, November 25, 2011

Notice of Public Meeting on Open Rulemaking Docket: 18 A.A.R. 25, January 6, 2012

Notice of Proposed Rulemaking: 18 A.A.R. 888, April 13, 2012

Notice of Public Meeting on Open Rulemaking Docket: 18 A.A.R. 899, April 13, 2012

5. The agency's contact person who can answer questions about the rulemaking:

Name:	Margaret McClelland
Address:	Arizona Department of Insurance 2910 N. 44th St. Phoenix, AZ 85018
Telephone:	(602) 364-2393
Fax:	(602) 364-2175
E-mail:	mmcclelland@azinsurance.gov
Web site:	http://www.id.state.az.us/

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Arizona Department of Insurance (Department) proposes this rulemaking to meet requirements established under the Patient Protection and Affordable Care Act (Pub. L. 111–148) (Affordable Care Act) so that Arizona can be designated by the federal Centers for Medicare & Medicaid Services (CMS) as a state that conducts effective review of individual health insurance rate increases. This designation would allow Arizona, rather than the federal government, to have oversight of proposed health insurance rate increases.

The Affordable Care Act, enacted on March 23, 2010, amends, and adds to the provisions of Part A of Title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. Section 1003 of the Affordable Care Act adds a new section 2794 of the PHS Act which directs the Secretary of the Department of Health and Human Services (the Secretary), in conjunction with the States, to establish a process for the annual review of "unreasonable increases in premiums for health insurance coverage." The statute provides that this process shall require health insurance issuers to submit to the Secretary and the applicable state justifications for unreasonable premium increases prior to the implementation of the increases. This provision is intended to help to moderate premium increases to individuals, families, and businesses who buy health insurance in these markets and to furnish information to consumers about why their premiums have increased.

On May 23, 2011, CMS issued a final regulation for Rate Increase Disclosure and Review, codified at 45 C.F.R. §§ 154.101-154.301 (the federal regulations), under which a proposed rate increase of 10 percent or more, known as a threshold rate increase, is subject to the effective rate review disclosure requirements specified in the federal regulations. The federal regulations provide that, as of September 1, 2011 CMS, will conduct the review of threshold rate increases, except that CMS may defer to the results of review conducted by a state, if the state process and standards meet the effective rate review requirements established in the federal regulations.

On June 24, 2011, CMS and the Center for Consumer Information and Insurance Oversight (CCIIO) determined that Arizona does not meet the effective rate requirements in either the individual or small group health insurance markets. As a result, since September 1, 2011 CMS has reviewed threshold rate increases in Arizona and will continue to review threshold rate increases for as long as Arizona does not meet the effective rate review requirements.

In August 2010, the Department received a $1 million rate review grant from the U.S. Department of Health and Human Services (HHS). Such grants were made available to all states to help states create or enhance their premium rate review programs by ensuring that proposed rate hikes are comprehensively reviewed, bringing greater transparency and openness to the rating process. Under the grant, the Department held nine public meetings around the state with insurance industry and consumer group representatives to educate them on state rate review processes and to update them on the Department's progress under the grant. The Department explored issues involving transparency, technology, and compliance related to regulation of individual and small group health insurance rates. The Department also gathered information about what would be helpful in improving the Department's procedures and processes for regulating health insurance rates.

In September 2011, the Department received an extension of the federal grant to gain additional time to complete the activities initiated under the 2010 rate review grant and to explore options for meeting the federal effective rate review standards. The Department then focused on completing the tasks initiated during the original grant period and completing a rulemaking necessary for Arizona to become an effective rate review state, beginning with individual health insurance and, later, small group health insurance.

In preparation for proposal of this rulemaking, the Department held two stakeholder meetings attended by representatives of the regulated industry and consumer organizations. A formal advisory committee was established and the committee participated in the rule drafting process. The Department held publicly noticed meetings to discuss the draft rulemaking and received both oral and written comments on the draft rules during this informal rulemaking process. The Department incorporated feedback received on the rulemaking to the extent possible without making this rulemaking more stringent than the federal regulations. Consequently, these rules closely mirror the requirements established in 45 CFR 154 regarding disclosure and review of health insurer rate increases with minor adjustments made to tailor the rulemaking to requirements in the Administrative Procedure Act in A.R.S. Title 41, Chapter 6 and rule drafting requirements in A.A.C. Title 1, Chapter1, Article 4. See cross-reference Table A below.

The Department has received expressions of support for the rulemaking from both the regulated industry and consumer interests who participated in the rule drafting and public comment processes. The regulated industry supports state-level regulation by the Department, as opposed to regulation by the federal government. This will allow for communication with state regulators to address issues and concerns at the state level. The consistency of the proposed state rules with the federal regulations will provide for consistency from state-to-state regarding requirements with which the companies must comply, easing their compliance burden. Consumer interests also support the provisions in the rules for transparency that will provide more information to consumers about the rates that they are paying for health insurance premiums and accountability by insurers to local regulators. Consumers also will continue to have access at the state level, through the Department, for information and redress of issues and concerns regarding health insurance rates. A draft of this rulemaking has been reviewed by CMS and the Department has received feedback from CMS indicating support for the rulemaking and the Departments efforts to become an effective rate review state. The rules in Article 23 closely mirror the corresponding federal regulations, as in indicated in Table A.

Table A
Effective Rate Review – Article 23
Cross-Reference to Federal Regulations

20 A.A.C. 6, Article 23	45 CFR §
R20-6-2301(A)	154-101(b)
R20-6-2301(A)(1)	154-101(b)
R20-6-2301(B)(3)	154-102
R20-6-2301(B)(4)	154-102
R20-6-2301(B)(9)	154-102
R20-6-2301(B)(10)	154-215(b)
R20-6-2301(B)(11)	154-102
R20-6-2301(B)(12)	154-102
R20-6-2301(B)(13)	154-200
R20-6-2301(B)(15)	154-102, 154-205
R20-6-2301(B)(15)(a)	154-205(b)(1)
R20-6-2301(B)(15)(b)	154-205(b)(2)
R20-6-2301(B)(15)(c)	154-205(b)(3)
R20-6-2301(B)(15)(d)	154-205(c)
R20-6-2301(B)(15)(e)	154-205(d)
R20-6-2302(A)	154-215(b)
R20-6-2302(A)(1)	154-215(e)
R20-6-2302(A)(2)	154-215(f)
R20-6-2302(A)(2)(a)	154-215(f)(i)
R20-6-2302(A)(2)(b)	154-215(f)(2)
R20-6-2302(B)	154-215(d)
R20-6-2303(A)	154-220(a)
R20-6-2303(B)	154-220(b)
R20-6-2304	154.230(a)
R20-6-2304(1)	154.230(a)
R20-6-2304(2)	154.230(a)
R20-6-2304(2)(a)	154.230(b)
R20-6-2304(2)(b)	154.230(b)
R20-6-2304(2)(c)	154.230(b)
R20-6-2304(3)	154.230(c)
R20-6-2304(3)(a)	154.230(c)(1)
R20-6-2304(3)(b)	154.230(c)(2)
R20-6-2304(3)(b)(i)	154.230(c)(2)(ii)
R20-6-2304(3)(b)(ii)	154.230(c)(2)(iii)
R20-6-2304(3)(c)	154.230(c)(3)
R20-6-2305(A)	154.301
R20-6-2305(A)(1)	154.301(a)(3)(i)
R20-6-2305(A)(2)	154.301(a)(3)(ii)
R20-6-2305(B)	154.301(a)(4)
R20-6-2305(B)(1)	154.301(a)(4)(i)
R20-6-2305(B)(2)	154.301(a)(4)(ii)
R20-6-2305(B)(3)	154.301(a)(4)(iii)
R20-6-2305(B)(4)	154.301(a)(4)(iv)
R20-6-2305(B)(5)	154.301(a)(4)(v)
R20-6-2305(B)(6)	154.301(a)(4)(vi)
R20-6-2305(B)(7)	154.301(a)(4)(vii)
R20-6-2305(B)(8)	154.301(a)(4)(viii)

R20-6-2305(B)(9)	154.301(a)(4)(ix)
R20-6-2305(B)(10)	154.301(a)(4)(x)
R20-6-2305(B)(11)	154.301(a)(4)(xi)
R20-6-2305(B)(12)	154.301(a)(4)(xii)

The Department continues to enforce Arizona's laws regarding rate increases that are not threshold rate increases under the federal regulations. Consequently, both the Department and CMS regulate specific aspects of certain rate increases in Arizona. If Arizona is designated as an effective rate review state as a result of this rulemaking, Arizona will have the regulatory authority to regulate threshold rate increases in Arizona.

To date, at least 44 states, the District of Columbia and three territories have been determined by CMS to have met the requirements of the federal regulations for effective rate review and are the regulators for threshold rate increases in their jurisdictions. In order to be allowed to review threshold rate increases in Arizona, it is necessary that the Department promulgate this rulemaking so that Arizona can be designated by CMS as an effective rate review state for individual health insurance.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

Oliver Wyman Study Regarding Effective Rate Review in Arizona's Individual Market, October 17, 2011. The study is available at http://www.id.state.az.us/RateReview/index.html. The study is also available at the Department. Any data underlying the study and any analysis or supporting material is included in the study.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

A. The economic, small business and consumer impact summary

This economic, small business, and consumer impact statement (EIS) addresses the requirements under A.R.S. § 41-1055. In this EIS, minimal impact means $5,000 or less. Moderate impact means more than $5,000, but less than $10,000. Substantial means $10,000 or more.

1. An identification of the rulemaking

The Arizona Department of Insurance (Department) proposes this rulemaking to meet requirements established under the Patient Protection and Affordable Care Act (Pub. L. 111–148) (Affordable Care Act) so that Arizona can be designated by the federal Centers for Medicare & Medicaid Services (CMS) as a state that conducts effective review of individual health insurance rate increases. This designation would allow Arizona, rather than the federal government, to have oversight of proposed health insurance rate increases.

The Affordable Care Act, enacted on March 23, 2010, amends, and adds to the provisions of Part A of Title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. Section 1003 of the Affordable Care Act adds a new section 2794 of the PHS Act which directs the Secretary of the Department of Health and Human Services (the Secretary), in conjunction with the States, to establish a process for the annual review of "unreasonable increases in premiums for health insurance coverage." The statute provides that this process shall require health insurance issuers to submit to the Secretary and the applicable state justifications for unreasonable premium increases prior to the implementation of the increases. This provision is intended to help to moderate premium increases to individuals, families, and businesses who buy health insurance in these markets and to furnish information to consumers about why their premiums have increased.

On May 23, 2011, CMS issued a final regulation for Rate Increase Disclosure and Review, codified at 45 C.F.R. §§ 154.101-154.301 (the federal regulations), under which a proposed rate increase of 10 percent or more, known as a threshold rate increase, is subject to the effective rate review disclosure requirements specified in the federal regulations. The federal regulations provide that, as of September 1, 2011 CMS, will conduct the review of threshold rate increases, except that CMS may defer to the results of review conducted by a state, if the state process and standards meet the effective rate review requirements established in the federal regulations.

On June 24, 2011, CMS and the Center for Consumer Information and Insurance Oversight (CCIIO) determined that Arizona does not meet the effective rate requirements in either the individual or small group health insurance markets. As a result, since September 1, 2011 CMS has reviewed threshold rate increases in Arizona and will continue to review threshold rate increases for as long as Arizona does not meet the effective rate review requirements.

In August 2010, the Department received a $1 million rate review grant from the U.S. Department of Health and Human Services (HHS). Such grants were made available to all states to help states create or enhance their premium rate review programs by ensuring that proposed rate hikes are comprehensively reviewed, bringing greater transparency and openness to the rating process. Under the grant, the Department held nine public meetings around the state with insurance industry and consumer group representatives to educate them on state rate review processes and to update them on the Department's progress under the grant. The Department explored issues involving transparency,

technology, and compliance related to regulation of individual and small group health insurance rates. The Department also gathered information about what would be helpful in improving the Department's procedures and processes for regulating health insurance rates. In September 2011, the Department received an extension of the federal grant to gain additional time to complete the activities initiated under the 2010 rate review grant and to explore options for meeting the federal effective rate review standards.

These rules closely mirror the requirements established in 45 CFR 154 regarding disclosure and review of health insurer rate increases with minor adjustments made to tailor the rulemaking to requirements in the Administrative Procedure Act in A.R.S. Title 41, Chapter 6 and rule drafting requirements in A.A.C. Title 1, Chapter1, Article 4. See cross-reference Table A below.

This rulemaking is supported by both the regulated industry and consumer groups who participated in the rule drafting process. The consistency of the rules with the federal regulations will provide for consistency with state-to-state requirements with which the companies must comply, easing their compliance burden. Consumer groups also support the provisions in the rules for transparency that will provide more information to consumers about the rates that they are paying for health insurance premiums and accountability by insurers to local regulators. Consumers also will continue to have access at the state level, through the Department, for information and redress of issues and concerns regarding health insurance rates. A draft of this rulemaking has been reviewed by CMS and the Department has received feedback indicating support for the rulemaking and the Departments efforts to become an effective rate review state.

The Department continues to enforce Arizona's laws regarding rate increases that are not threshold rate increases under the federal regulation. Consequently, both the Department and CMS regulate specific aspects of certain rate increases in Arizona. If Arizona is designated as an effective rate review state as a result of this rulemaking, Arizona will have regulatory authority to regulate threshold rate increases in Arizona.

To date, at least 44 states, the District of Columbia and three territories have been determined by CMS to have met the requirements of the federal regulations for effective rate review, in at least one market, and are the regulators for threshold rate increases in their jurisdictions. In order to be allowed to review threshold rate increases in Arizona, it is necessary that the Department promulgate this rulemaking so that Arizona can be designated by CMS as an effective rate review state for individual health insurance.

2. An identification of the persons who will be directly affected by, bear the costs of or directly benefit from the rulemaking.

The persons who will be directly affected by this rulemaking are health insurers that offer individual health insurance products in Arizona. Additionally, Arizona consumers of health insurance will benefit from this rulemaking. The Department will be affected as administrator of the rules. Some actuarial businesses that provide rate review services could benefit from this rulemaking as a result of contracting with the Department to perform those services.

3. A cost benefit analysis of the following:

(a) The probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the rulemaking.

The Department of Insurance

In 2010, the Department received a $1 million federal grant for conducting activities associated with having Arizona become an effective rate review state, including promulgating this rulemaking. The Department hired two full-time employees (FTEs) under the grant who are participating in activities related to promulgating this rulemaking. The grant funding and those positions are temporary and will end September 30, 2012. When the rulemaking becomes effective and Arizona is designated by CMS an effective rate review state, the Department will have responsibility for conducting review of threshold rate increases. The Department anticipates that this will not result in a need to hire additional FTEs, although some existing staff time will be required to implement a process for referring filings to contracted actuaries to conduct the actuarial reviews.

The Department will incur moderate to substantial costs for promulgation of this rulemaking.

Other agencies directly affected by the implementation and enforcement of the rulemaking

The Department does not expect the rulemaking to directly affect any other agencies.

(b) The probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the rulemaking.

The Department does not expect the rulemaking to directly affect political subdivisions of this state.

(c) The probable costs and benefits to businesses directly affected by the rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the rulemaking.

The businesses that will be directly impacted by this rulemaking are health insurers that offer individual health insurance products in Arizona. This rulemaking will have minimal to moderate economic impact on these businesses, as it will not have any new requirements for health insurers that the existing federal regulations do not already have, other

than filing copies of documentation and communicating with the Department, rather than, the federal government, if Arizona is determined to be an effective rate review state.

The rulemaking will not add any filing-submission costs for health insurers. However, state review may cost health insurers more than federal review costs them because the insurers will have to pay for actuarial review of each filing filed with the state. The federal government does not charge the insurer for the required actuarial review. However, the Department does not employ, nor does it intend to employ, actuaries to review the filings. Instead, the Department intends to use contracted external actuaries to do the reviews and the Department will bill health insurers for the cost of the review. The Department cannot state, at this point what the exact cost of the actuarial review will be because the Department has not yet contracted with any actuaries and the amount of time each review will take will vary. For actuaries who currently review other filings for the Department, the hourly rate for review ranges from $250 to $450 per hour. The Department is currently giving consideration to requesting an extension of the federal rate review grant. If the Department receives additional grant funds under the extension, the Department is considering using some of the grant funds to pay the cost of the contracted rate reviews for the first year or two, which would remove that economic impact from the insurers during that period.

The Department does not anticipate an effect on payroll expenditures of employers who are subject to this proposed rulemaking, as a result of this rulemaking.

In Arizona, there are approximately 14 insurers, with certificates of authority from the Department, actively soliciting and selling individual health insurance. Approximately 25 more certificated health insurers are covering insured individuals, but may or may not be actively soliciting or selling new business in Arizona. The vast majority of insured Arizonans are insured by a few companies. Blue Cross Blue Shield of Arizona insures approximately 130,000 individuals. Health Net Life Insurance Company and Health Net of Arizona, Inc. are the next largest carriers with, combined, approximately 14,500 insured individuals. Aetna Health, Inc. and Aetna Life Insurance Company insure, combined, approximately 9,600 individuals. Humana Insurance Company insures approximately 7,800 individuals. Cigna Health Care of Arizona insures approximately 4,100. The rest of the insurers, combined, insure approximately 4,500 individuals.

Health insurers who operate in Arizona and other states will also benefit from this rulemaking because Arizona will have an effective rate review program that is consistent with what is required under federal law and with other states that have rate review programs that are consistent with the federal requirements. This consistency could result in a cost savings to insurers as a result of not having to make adjustments to their operations because Arizona does not have a consistent rate review program.

Any cost to insurers is outweighed by the benefit to the consumers who will be protected by this rulemaking.

4. A general description of the probable impact on private and public employment in businesses, agencies and political subdivisions of this state directly affected by the rulemaking.

The Department does not anticipate that these rules will directly affect private and public employment in businesses, agencies and political subdivisions of this state.

5. A statement of the probable impact of the rulemaking on small businesses.

(a) An identification of the small businesses subject to the rulemaking.

Under A.R.S. § 41-1001(20):

"Small business" means a concern, including its affiliates, which is [1] independently owned and operated, which is [2] not dominant in its field and which [3] employs fewer than one hundred full-time employees or which had gross annual receipts of less than four million dollars in its last fiscal year.

The only businesses subject to the rulemaking are health insurers that offer individual health insurance products in Arizona. Health insurers generally do not fall within the definition of small business, but to the extent any do, they would be subject to this rulemaking.

(b) The administrative and other costs required for compliance with the rulemaking.

If there are any small businesses that are subject to this rulemaking, the administrative and other costs required for compliance would be the same as discussed in section (3)(c) above.

(c) A description of the methods that the agency may use to reduce the impact on small businesses.

The Department is not aware that any small businesses are subject to this rulemaking. But, to the extent any small businesses are subject to the rulemaking, the Department believes that these rules are written to have the least impact on small businesses, while meeting the statutory mandates of the corresponding federal legislation. The rules closely mirror the federal regulations to reduce the potential for impacts that are not a result of the federal regulations.

(i) Establishing less costly compliance requirements in the rulemaking for small businesses.

In order for Arizona to become an effective rate review state, it is necessary for the rules to closely mirror the federal regulations. The federal regulations do not provide for less costly schedules or less stringent deadlines for compliance, consequently, neither does this rulemaking.

(ii) Establishing less costly schedules or less stringent deadlines for compliance in the rulemaking.

In order for Arizona to become an effective rate review state, it is necessary for the rules to closely mirror the federal regulations. The federal regulations do not provide for less costly schedules or less stringent deadlines for compliance, consequently, neither does this rulemaking.

(iii) Exempting small businesses from any or all requirements of the rulemaking.

In order for Arizona to become an effective rate review state, it is necessary for the rules to closely mirror the federal regulations. The federal regulations do not provide for small businesses to be exempted from any or all requirements, consequently, neither does this rulemaking.

(d) The probable cost and benefit to private persons and consumers who are directly affected by the rulemaking.

Consumers of health insurance will be impacted by this rulemaking. This rulemaking does not regulate consumers and will have no negative regulatory economic impact on consumers. However, the rules will result in non-quantifiable benefits as a result of oversight by state regulators who understand the state health insurance market and have an effective and efficient regulatory relationship with the industry. The Department also expects non-quantifiable benefits as a result of greater disclosure of information and transparency regarding health insurance rate increases. Some disclosure and transparency improvements already exist under the federal regulations, but the Department expects to enhance those through its ability to reach out and respond at the state level to Arizona consumers. It is possible that insurers might increase premiums in order to pass on to consumers the cost of added disclosure and transparency requirements, but, with the exception of actuarial review costs, these are already required under the federal regulations.

6. A statement of the probable effect on state revenues.
The Department expects no impact on state revenues as a result of this rulemaking.

7. A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking
The Department believes that this rule is written to be the least intrusive method of achieving the purpose of the proposed rules. The rules closely mirror the federal regulations to reduce the potential for additional intrusion or costs that are not a result of the federal regulations.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department is making a change to add text to R20-6-2301 for clarity. R20-6-2301(A)(1) is revised as follows:

1. Health insurance that a health insurer issues to an employer or to any group described in either A.R.S. § 20-1401 or A.R.S. § 20-1404(A), except health insurance issued to an association or its individual members as described in R20-6-2301(B)(7)(b);

This clarification avoids what might be misinterpreted as an inconsistency regarding whether Article 23 applies to rates charged by health insurers for insurance for any group described in either A.R.S. § 20-1401 or A.R.S. § 20-1404(A) and the definition of individual health insurance under R20-6-2301(B)(7)(b). This change references text that already exists in R20-6-2301(B)(7)(b) and clarifies that while it does not apply to groups in general, the Article does apply to an association of individuals under R20-6-2301(B)(7)(b).

The Department added the following text to R20-6-2303 as directed by the Council at the October 2, 2012 Council meeting:

C. The Department shall provide access from its website to the Parts I and II of the Preliminary Justifications of the proposed rate increases that it reviews and have a mechanism for receiving public comments on those proposed rate increases.

The word "Submission" in the heading for R20-6-2305 is changed to "Documentation" to correct a clerical error. Other minor technical changes were made at the request of the Governor's Regulatory Review Council staff.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The Department held oral proceedings in Tucson, Phoenix and Flagstaff. The Department received oral comments from 17 members of the public and over 1,000 comment letters. All but three of the comment letters were form comment letters received from Consumers Union Advocacy (CUA) on behalf of its constituents. While the letters received from CUA were numerous, all the letters were form letters that contained the exact same six core comments, which are addressed in the summary below. Also, 31 of those form letters contained a comment in addition to the four core comments. Those additional comments are also addressed in the summary below.

While the Department received a substantial number of comments, the majority of the comments related to matters outside the limited scope of this rulemaking or requested that the Department make the rules more stringent than the corre-

sponding federal regulations, which is prohibited without specific authority. Additionally, some comments requested that the Department write rules to regulate the Department. The Department is making no changes to the rules based on the comments received.

Comment	Department's Response
Phoenix Oral Proceeding	
Gemmrig	
The commenter stated that she had insurance that she never used but her rates increased so much that she had to cancel it. Her mother had benefits dropped without reason. The commenter wants insurers to have more transparency and wants rate review and prior approval to protect customers from unnecessary increases.	R20-6-2304(3)(b) improves transparency by requiring health insurers to post information on their web sites, such as when the insurer wants to increase insurance rates for individual health insurance policies by an average of 10% or more, the proposed date of the increase, and the number of people expected to be impacted by the increase. The insurer must also explain why it wants to raise the premium, provide information on the last three rate increases, and if an increase is found to be unreasonable, the insurer must justify why it wants to implement the unreasonable increase. Additionally, the Department has enhanced its web site to improve transparency by providing a link from its web site to the federal web site that contains information for rates in Arizona, including the Parts I and II of the preliminary justification described in R20-6-2302(A). The Department will provide, on its web site, a mechanism for receiving public comment on proposed rate increases. The Department has also posted a rate increase Frequently Asked Questions (FAQ) on its web site to provide more information on rate review questions frequently asked by the public. The Department is also placing on its web site an educational program called the "Rate Detective," an online search tool that will allow the public to easily access the health insurance rate and form filings that insurers have made in compliance with the Affordable Care Act. Regarding prior approval of rate increases, neither Arizona statute, nor the federal regulations after which Article 23 is closely modeled, gives the Department authority to approve or disapprove individual insurance rate increases; therefore, a prior approval requirement is beyond the scope and authority of this rulemaking.
Dean	

The commenter expressed concern over experience with rate increases of up to 50% for individual major medical policies and requested that the Department give protection from the increases. The commenter expressed concern that consumers cannot afford to fund their health savings accounts.	Arizona law does not give the Department the authority to disapprove rate increases, no matter the percentage of the increase. The federal regulations, after which this rulemaking is closely modeled, also do not give the federal government authority to disapprove or approve individual rate increases, no matter the percentage of the increase. Arizona law requires that the Department have specific statutory authority to make an Arizona rule more stringent than the corresponding federal regulation. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulations. Establishing or assuring the affordability of health savings accounts is beyond the scope of authority for this rulemaking.
Bonnett - Arizona Public Health Association	
The commenter wants the Department to ensure affordable coverage through: 1. Regulator authority to reject unreasonable rate increases; 2.improved transparency; 3. public voice in rate review process	The Department does not have authority, either through state statute or federal regulation, to disapprove individual rate increases, nor does the Department have statutory authority to make these rules more stringent then the federal regulations. R20-6-2304(3)(b) improves transparency by requiring health insurers to post information on their web sites, such as when the insurer wants to increase insurance rates for individual health insurance policies by an average of 10% or more, the proposed date of the increase, and the number of people expected to be impacted by the increase. The insurer must also explain why they want to raise the premium, provide information on the last three rate increases, and if the increase is found to be unreasonable, the company must justify why they want to implement the unreasonable increase. Additionally, the Department has enhanced its web site to improve transparency by providing a link from its web site to the federal web site that contains information for rates in Arizona, including the Parts I and II of the preliminary justification described in R20-6-2302(A). The Department will provide, on its web site, a mechanism for receiving public comment on proposed rate increases. The Department has also posted a rate increase FAQ on its web site to provide more information on rate review questions frequently asked by the public. The Department is also placing on its web site an educational program called the “Rate Detective,” an online search tool that will allow the public to easily access the health insurance rate and form filings that insurers have made in compliance with the Affordable Care Act.

A number of commenters commented that there should be prior approval of rates.	Arizona law does not provide authority for the Department to require insurers to obtain approval of rate increases prior to implementing them. The federal regulations after which Article 23 is closely modeled also do not require insurers to obtain federal approval of rate increases prior to implementing them. A prior approval requirement in Arizona is beyond the scope and authority of this rulemaking.
The rule should include a method for information to be provided to the public in a common language.	It is not clear what the commenter is requesting regarding a common language, but the rules do require information to be provided to the public under the previously discussed transparency requirements.
Jewett – Children's Action Alliance	
For rate increases over 10% there should be a narrative for consumers to read that justifies the increase.	R20-6-2302(A) does require a narrative to justify the increase. It requires a preliminary justification that includes, as its Part II, a written description that justifies the rate increase and that contains a simple and brief narrative describing the data and assumptions the health insurer used to develop the rate increase. It also requires an explanation of the most significant factors causing the rate increase and a brief description of the overall experience of the policy. In conjunction this rule, the Department will provide a link from its web site to the federal web site that contains this information.
A rate increase deemed unjustified should be prominently displayed on Department web site and through a press release.	The Department is considering appropriate, cost effective methods to notify interested consumers, and the general public, when it determines that a rate increase is unreasonable. These methods may include web postings and press releases.
Requests an email subscription so that people can find out if a certain company's rate increase has been deemed unreasonable	The Department is considering appropriate, cost effective methods to notify interested consumers and the general public when it determines that a rate increase is unreasonable. These methods may include wide-distribution e-mails or a ListServ.
Rate review regulation must be at least as strong as the federal process or there is no benefit to consumers.	This rulemaking is closely modeled after the federal rate review regulations at 45 CFR §§ 154.101 thru 154.301, and gives the Department the same authority to review individual rates that the federal government currently has under the federal regulations.
Rates over the threshold should allow for consumer comment and feedback.	It is a federal requirement that any state with effective rate review status must have a mechanism for receiving public comments on proposed rate increases. Accordingly, while not a part of this rulemaking, the Department will provide, on its web site, a mechanism for receiving public comment on proposed rate increases. The Department is considering appropriate, cost effective methods to notify interested consumers and the general public when it determines that a rate increase is unreasonable. These methods may include web postings, wide-distribution e-mails and press releases.
Hourican - Code Pink	

The commenter suggested improved transparency by requiring the Department to make following information publicly accessible to consumers enabling transparency and consumer access: 1. Reason for rate increase; 2. Information on expected impact of the rate on consumers, maybe public panels and the anticipated medical trend; 3. The level of administrative spending; and 4. The profit margin with full claims data, methodology.	This rulemaking addresses most of commenter's transparency and consumer access concerns. Every rate increase to which this rulemaking applies must include a preliminary justification that includes: An explanation of the most significant factors causing the rate increase, i.e., the "reason for the rate increase." R20-6-2302(A)(2)(a) Per-enrollee, per-month allocation of projected premium, i.e. "information on the expected impact of the rate on consumers." R20-6-2302(A)(1)(e). Disclosure requirements that collectively include "full claims data, methodology". R20-6-2302(A). Trend projections related to utilization, and service or unit cost, i.e. "anticipated medical trend". R20-6-2302(A)(1)(b). The federal regulation does not include a requirement that states conduct public panels on rate increases. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulations. The federal regulations upon which Article 23 is closely modeled do not require insurers to disclose the level of administrative spending. The Department does not have the statutory authority to exceed the requirements of the enabling federal regulations. However, the rulemaking does require disclosure of the impact of non-claims costs on the rate increase. R20-6-2302(A)(1)(d), R20-6-2302(A)(2)(a). The federal regulations do not require insurers to disclose the profit margin. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulations. Though not required by this Article, in support of furthering transparency, the Department will provide a link on its web site to the federal web site that contains this preliminary justification.
Flagstaff Oral Proceeding	

Dove	
Double digit insurance rate increases are out of hand and exploit small businesses and there is no justification for it.	Arizona law does not give the Department the authority to disapprove rate increases, no matter how large they are. The federal regulations after which this rulemaking is closely modeled do not give the federal government authority to disapprove or approve individual rate increases, no matter how large they are. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulations. Establishing or assuring the affordability of individual health insurance is beyond the scope and authority of this rulemaking.
Young	
Rate increases should be linked to the cost of living, general cost of living, or the inflation rate?	Arizona law does not give the Department the authority to require health insurers to link health insurance rate increases to these factors. The federal regulations after which this rulemaking is closely modeled do not give the federal government authority to disapprove or approve individual rate increases, no matter how large they are. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulations.
The rates go up and the co-payments go up at the same time, and you end up paying more than you had any idea of because things are not covered, or the co-payments themselves become really, really high.	Arizona law does not give the Department the authority to limit co-payments. The federal regulations after which these rules are closely modeled do not give the federal government authority to limit co-payments. The Department does not have statutory authority to exceed the requirements of the corresponding federal regulations.
Wants up-front plain-language transparency regarding what's covered, what's not covered, what are co-payments and what things mean so that people can understand.	It appears the commenter is referring to information regarding what is or is not covered by a health insurance policy and definitions of terms related to insurance policies. The Department appreciates that insurance can be confusing, but these matters are not the subjects of this rulemaking.
Estes Dowden	
Insurance is confusing and hard to understand. It is hard to get a clear explanation or interpretation. Plain language and transparency up front. Different rates for different types of the same plan is confusing and needs to be simple.	The Department believes that this rulemaking improves transparency by requiring health insurers to post information on their web sites that can help the public understand insurance rates. Additionally, the Department has enhanced its web site to improve transparency and understanding by including features such as the FAQ and the Rate Detective and by providing a link from its web site to the federal web site that contains information for rates in Arizona.
Healey	

Comment that the Department should monitor affordability and healthcare cost containment and shifting. Recommends the release of contracting conditions to limit annual maximum price increases for inpatient and outpatient services to the relevant CMS hospital price index.	While these are important issues, establishing or assuring the affordability of individual health insurance, requiring healthcare cost containment and limiting cost-shifting shifting are all beyond the scope of this rulemaking. Arizona law does not give the Department the authority to set pricing or other contracting conditions between insurers and providers. The federal regulation after which this rulemaking is closely modeled does not give the federal government authority to take such actions. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulation.
When reviewing filings for rate increases, consider the intention to increase expenses on primary care by one percent per year.	It is not clear what the commenter means by this comment; however, the Department does not have the statutory authority to include requirements in this rulemaking that are not consistent with the requirements of the corresponding federal regulation.
Consider allowance for medical home initiatives.	Allowance for medical home initiatives is not the subject matter of this rulemaking.
Allow adjustments for intended electronic medical recordkeeping.	This is not the subject of this rulemaking.
Use rate review to address broader healthcare delivery system reform issues such as differential pay between specialists and primary care physicians; provider payment rates; and how to incentivize primary care.	Arizona law does not give the Department the authority to address these broader healthcare delivery system reform issues. Additionally, this is beyond the purview of the authority given under the federal regulations. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulation.
Recommend a hearing on any rate increase by any of the only five companies that have over five percent of the market in Arizona. One company has 49 percent of the individual market.	The federal regulation after which this rulemaking is closely modeled does not include a requirement that states conduct public hearings on rate increases. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulation.
Rate decisions should be posted online and made available to the press.	The Department is considering appropriate, cost effective methods to notify interested consumers and the general public when it determines that a rate increase is unreasonable. These methods may include web postings and press releases.
In terms of the issue of transparency above ten percent, rate review results should be published.	The Department will provide a link on its web site to the federal web site that will publish information on rates that are ten percent or more. The Department is considering appropriate, cost effective methods to notify interested consumers and the general public when it determines that a rate increase above ten percent is unreasonable.
Tucson Oral Proceeding	
Shapiro	
Commenter supports the rule. Rule only applies to a very tiny portion of the Arizona community, those people who are purchasing insurance on their own, so anything to improve access to care would be helpful.	The Department appreciates the importance of access to care, however that is a matter beyond the scope and authority of these rules.

Benefit buy-down can result in lower observed premiums but may reduce access to care or increase out-of-pocket expenditures. To increase transparency, look at the total cost to the consumer not just the premium cost. The insurance companies cannot increase premiums over 10 percent so the rule doesn't apply, but the effect of cost to consumers is greater because they shift the burden through increased deductibles, cost-sharing and other measures.	This rulemaking applies to regulatory review of rate increases for individual major medical health insurance. The impact of cost-sharing on total cost to consumers, and transparency regarding cost-sharing and total cost are matters beyond the scope and authority of these rules.
The commenter stated that there was a survey by Buck Consultants of 129 million insurers and administrators that showed rate increases over the past year of 9.9 percent for PPOs, point of service plans, health maintenance organizations and high deductible health plans. The commenter suggested looking to see if there is a trend of rate increases of 9.9 percent over the years to get around regulations.	The commenter did not provide a copy of this survey, so the Department cannot comment on the survey. The Department is required to make rules that are consistent with the corresponding statutory authority, which, currently, addresses rates increases above 10%.
Springer	
Insurance is complicated and consumers need information about how their health premiums are calculated, particularly when those premiums are increased.	The Department agrees with this comment and believes that this rulemaking will provide consumers with important and helpful information not previously available to them regarding insurance rates and rate increases.
The Department should conduct rate reviews in ways which protect consumers and give them tools to make informed decisions.	The Department believes that this rulemaking will provide consumer information and protections in ways not previously provided. As the regulator, these rules will also provide the Department with authority for requiring greater disclosure and transparency that will provide for more effective and efficient regulatory oversight over insurers. This will enhance the Department's ability conduct rate reviews in ways that are more protective to consumers.
Insurers should be required to provide all information related to a rate increase to the Department, and the Department should make that information available to consumers on an easy to use, understand and find web site so that consumers can find the data and make comparisons.	A previously discussed, Article 23 establishes more extensive information submission requirements than those that currently exist in Arizona. The requirements, under R20-6-2304(3), enhance transparency by establishing web site disclosure requirements for health insurers for certain rate increases. In addition, in conjunction with promulgating these rules, the Department will provide a link from its web site to the federal web site that contains the Parts I and II of the preliminary justification described in proposed R20-6-2302(A) and will provide on the Department's web site a mechanism for receiving public comment on proposed rate increases. The Department has posted a rate increase FAQ on its web site and is implementing an educational program called the Rate Detective.
Brown - Arizona PIRG Education Fund	
The commenter notes that support for the process does not mean an endorsement of the proposed rules as written.	The Department acknowledges receipt of the comment.

Table A, which is the cross-reference listing of the federal regulation and the proposed rule doesn't line up in Section 301.b, which is the transparency and comment part of the federal regulation, and we believe it's critical for an effective process in Arizona. The proposed rule by itself would not create an effective rate review program under the CMS regulation because it does not contain the provisions of Section 154.301(b).	45 CFR 154.301(b) states, "A state with an Effective Rate Review Program must provide [access to the preliminary justification] and have [a public comment mechanism]". The Department agrees (1) that it must comply with these federal requirements in order for Arizona to be designated as an effective rate review state, and (2) that the proposed rulemaking will not, by itself, create an effective rate review program. In addition to the 45 CFR 154.301(b) requirement cited by this commenter, the federal regulations set forth other requirements for a state to have an effective rate review program. *See e.g.,* 45 CFR 154.210(b)(2) (the state has to inform CMS of any finding of unreasonableness); 45 CFR 154.301(a)(1) (the state must receive certain data and documentation from insurers); 45 CFR 154.301(a)(2) (the state must have an effective and timely rate review process); 45 CFR 154.301(a)(3) (the state must include certain factors in its review of a rate increase request.) These are obligations that the CCIIO will impose on the Department. The Department is aware of and will meet all of its obligations for these requirements in order to have an effective rate review program. The purpose of this rulemaking is to require regulated entities to take the required steps and provide the required information that the Department must have in order to meet these obligations.
R20-6-2302 shows that the insurer needs to disclose the information to ADOI and CMS, but in turn it doesn't say that ADOI needs to disclose this information to the public.	As noted in the preceding response, the federal regulation sets forth requirements a state must meet in order for that state to have an effective rate review program. The provision of the federal regulation that is parallel to R20-6-2302 does not regulate the Department by requiring that the Department disclose information to the public. See 45 CFR 154.215. However, as stated on the previous response, the Department is (1) aware of the federal requirement set forth in 45 CFR 154.301(b) which states, "A state with an Effective Rate Review Program must provide [access to the preliminary justification] and is (2) aware that it must comply with this federal requirement, among others, in order for Arizona to be designated as an effective rate review state. That is why, while not included as a requirement in the rules, the Department is committed to providing and facilitating access to information to the public through the Department's web site.
R20-6-2304, requirement that the insurer who moves ahead with implementing unreasonable rate increases prominently post it on its web site does not meet the federal requirement because it requires the insurer to post the information. It does not state that the information is going to be available through the state site.	The provision of the federal regulation that is parallel to R20-6-2304 does not regulate the Department by mandating that the Department post this information on Department's web site. *See* 45 CFR 154.230. However, while not included as a rule requirement, the Department is committed to facilitating public access to information through appropriate posting of information, or links to information, on the Department's web site.

R20-6-2304 pertains to the final justification rather than the preliminary justification, and it applies to only rate increases found to be unreasonable, where the insurer is implementing them anyway, rather than to all rate increases the state reviews.	R20-6-2304 relates to all determinations of unreasonableness.
Consumer comments should be made a part of the rule or ADOI should, at a minimum, announce that they will be added through a separate rule or an informal process.	The federal regulation does not refer to consumer comment. It refers to public comment twice. One statement describes an action CMS will take. 45 CFR 154.215 (j). The other describes an action a state must take in order to have an effective rate review program. 45 CFR 154.301(b). The regulation does not provide for consumer comments to be made a part of the rules. However, while not a part of these rules, the Department will provide, and post on its web site, a mechanism for receiving public comment on proposed rate increases.
The proposed rule doesn't contain specific documentation requirements for exactly what the insurer must provide regarding information and how they must submit it. This should be clarified in the rule, leaving the door open for potential technological advances that can enhance the ability for consumers to have information, but at least to minimally contain some of that information that will be collected over time.	The provisions in this rulemaking for documentation requirements for what the insurer must provide regarding information and how they must submit it are the same as those in the federal regulation in 45 CFR 154.215. The Department does not have statutory authority to expand those corresponding federal regulations by rule.
R20-6-2301(A)(15)(b) *[sic]* defines an unreasonable rate increase as an increase where one or more of the assumptions on which the health insurer based the rate increase is not supported by sound actuarial reasoning, data and analysis. PIRG interprets that Section 154.205.b.2 provides that the rate increase is unreasonable if one or more of the assumptions on which the rate increase is based is not supported by substantial evidence. Sound actuarial reasoning sounds like it would involve significant deference to the opinion of the insured's actuaries as to the practice of their profession, rather than looking at whether there is enough evidence in the rate filing to support the proposed rate.	The Department agrees that the text in R20-6-2301(B)(15)(b) is not exactly the same as the parallel federal provision in 45 CFR 154.205.b.2. This rulemaking substitutes the term "sound actuarial reasoning, data and analysis" for "substantial evidence". During its informal rule drafting process with stakeholders, the Department received verbal feedback from insurers that "substantial evidence" was vague and the industry would not understand the standard being applied. Our consulting actuary (Mercer Health, LLC) advised us that the term "sound actuarial reasoning, data and analysis" would clarify the standard without making it more stringent. While the wording is different, it is not a different standard of compliance, but a clearer, equivalent statement of the type of evidence used in a substantial evidence standard. The Department believes this change is one that makes the rule more clear and understandable, but does not change the meaning or standard.
One area that we'd like to encourage you to include that is not in the federal regulation is the requirement that insurers disclose the rating factors that they use, such as age factors, area factors, especially if there are changes in these factors that impact the overall rate increase.	The Department does not have the statutory authority to exceed the requirements of the enabling federal regulations. However, the Department expects that most insurers will include this information in the "explanation of the most significant factors causing the rate increase" required under R20-6-2302(A)(2)(a).
The commenter supports the requirement that some rate increase justifications be submitted 60 days before they go into effect.	The Department acknowledges the support of specification about when the submission occurs.

The commenter urges improved transparency, to help increase consumer involvement and ultimately make Arizona's rate review process more effective in protecting consumers by preventing unreasonable rate increases from going into effect.	The Department believes that this rulemaking will improve transparency, as previously discussed, through enhancements in web site disclosures, a mechanism for public comment on proposed rate increases, the FAQ and the Rate Detective program.
Brown – Arizona PIRG letter	
The rule states that the Department will accept whatever threshold the Secretary of HHS sets. The rule should contain a provision that ADOI will consult with the Secretary as the decision for a threshold rate increase is being determined.	The federal regulations provide that the Secretary of Health and Human Services shall consult with a state when setting a state-specific threshold. Because the Department does not regulate the Secretary, the Department will not place in its rule such a mandate for the Secretary, but Department expects to have that kind of consultation with the Secretary.
The rules should clearly state that ADOI will perform rate review of increases above the threshold, and clarify how this process will work, including a timeline for review and ADOI should notify the insurer and CMS at the same time that they have found the rate increase to be unreasonable, rather than informing CMS and then waiting for CMS to inform the insurer.	While requirements for the Department will not be a part of these rules, the Department is considering a review process that is consistent with the process contemplated in the federal regulations, both for its own regulatory purposes and to meet the requirements to be designated by CCIIO as an effective rate review program. This process might include notifying the insurer and CMS at the same time regarding unreasonable rate increases. The Department will evaluate the need for further rulemaking, as necessary.
The rule does not indicate what happens if the information the insurer provides is not complete. CMS regulation requires CMS to request additional information if it is required to make a determination as to reasonableness, and the insurer must provide it within 10 days (Section 154.215.h). (This same comment also received in the Sobel – Consumers Union letter) A parallel provision should go into Arizona statute.	While requirements for the Department will not be a part of these rules, the Department agrees that it must comply with the requirements of 45 CFR 154.215(h) in order for Arizona to be designated as an effective rate review state. These are obligations that the CCIIO will impose on the Department, but does not require in these rules. The Department is aware of and will meet all of its obligations for these requirements in order to have an effective rate review program. The purpose of this rulemaking is to require regulated entities to take the required steps and provide the required information that the Department must have in order to meet these obligations. The Department will evaluate the need for further rulemaking, as necessary. The Department cannot, with this rulemaking, revise Arizona statute.
Warren	

The commenter supports transparency process with insurance companies as these new plans roll out, that first of all is to be very, very clear about why any increases in insurance have to be made and that those be outlined not only to the insurance commission but also to the insureds, future insureds, to the public.	R20-6-2304(3)(b) requires insurers to post information on their web sites, such as when the insurer wants to increase insurance rates for individual health insurance policies by an average of 10% or more, the proposed date of the increase, and the number of people expected to be impacted by the increase. The insurer must also explain why it wants to raise the premium, provide information on the last three rate increases, and if increase is found to be unreasonable, the company must justify why it wants to implement the unreasonable increase. Additionally, the Department has enhanced its web site to improve transparency by providing a link, from its web site to the federal web site, that contains information for rates in Arizona, including the Parts I and II of the preliminary justification described in proposed R20-6-2302(A). The Department will also have the Rate Detective available on its web site. All of this information is available to insureds and the public.
The commenter supports requiring insurance companies, who are asking for rate increases, to prepare materials that can be compared side-by-side with other insurance or other offerings in terms of the details of the coverage of all kinds, and not only basic health services coverage, hospital coverage, physician coverage, but also those other benefits that may be offered and to be very clear what the copays are, the deductibles, the freebies that are being given.	Arizona law does not give the Department the authority address these broader healthcare issues. Additionally, this is beyond the purview of the authority given under the federal regulations. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulation.
The commenter supports publicly noticed rate review hearings with consumer accessibility and participation.	The federal regulation after which this rulemaking is closely modeled does not include a requirement that states conduct public hearings on rate increases. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulation.
Grabb	
The commenter expressed concern that as a result of rate increases, patients cannot afford their medications and copays and that patients do not understand deductibles and limits on coverage. The commenter supports improved information that gets to the patient before they get to the doctor's office.	Neither state nor federal law gives the Department authority to limit rate increases. Establishing or assuring the affordability of individual health insurance is also beyond the scope of this rulemaking. The Department agrees that consumers need better information. With regard to transparency that relates to the scope of these rules, the rules will provide for transparency and information as previously discussed.
Sobel – Consumers Union letter	

The proposed rule falls short of the minimum requirements under the federal law to be deemed an "effective" state in four areas: Transparency, Consumer Comment, Timeliness, and Standard of Review. The proposed Arizona rule does not have a provision for disclosure of Parts I and II on its web site, nor is there a provision for consumer comments.	45 CFR 154.301(b) states, "A state with an Effective Rate Review Program must provide [access to the preliminary justification] and have [a public comment mechanism]". The Department is aware that it must comply with these federal requirements in order for Arizona to be designated as an effective rate review state; however, the federal regulation does not require that the Department include these provisions in its rules. The purpose of this rulemaking is to require regulated entities to take certain steps and provide certain information that the Department must have in order to meet these obligations. While not included as a requirement in the rules, the Department is committed to providing access to this information to the public through the Department's web site
Oregon and California have used some of the grant money from Health and Human Services (HHS) to fund a consumer organization to comment on proposed rates. Without this funding, it is difficult for consumer groups to have the resources necessary to file substantial comments that would be helpful to regulatory review. Arizona should consider re-granting some of the funds received from HHS to consumer organizations.	The commenter's request is beyond the scope of this rulemaking and beyond the scope of authority that the Department has under state or federal law.
The proposed rule only requires that plans submit preliminary justification for threshold rate increases to the Department and CMS at the time of the filing. The rule makes no mention of how long the Department will take to review the filing. Committing to review in a specified time period would be essential.	While requirements for the Department will not be a part of these rules, the Department will develop and document a review process that is consistent with the process contemplated in the federal regulations, both for the Department's own regulatory purposes and to be designated by CCIIO as an effective rate review program. These are obligations that the CCIIO will impose on the Department, but does not require in these rules. The Department is aware of and will meet all of its obligations for these requirements in order to have an effective rate review program. The purpose of this rulemaking is to require regulated entities to take the required steps and provide the required information that the Department must have in order to meet these obligations. The Department will evaluate the need for further rulemaking, as necessary.
The rule should include the federal standard of review for determining an unreasonable rate increase.	The substantive requirements of this rulemaking are consistent with the substantive requirements of the federal regulation.
We urge Arizona to consider including a prior approval requirement, with the ability of the regulator to consider the whole financial picture of the health insurance company, when determining whether to approve a proposed rate. Oregon regulators, which have this authority, have been able to save consumers over $37 million over the last two years.	The Department does not have authority, by state statute, or federal regulation, to require prior approval. The federal regulations after which this rulemaking is closely modeled do not give the federal government authority to disapprove or approve individual rate increases. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulation. A prior approval requirement is beyond the scope of this rulemaking.
Bonnett – Arizona Public Health Association letter	

The commenter suggests implementing strategies that will strengthen our health insurance rate review process including: • authorizing regulators to reject unreasonable rate increases • improving transparency • ensuring that consumers have a voice in the rate review process.	Regarding transparency and a public voice in the rate review process, R20-6-2304(3) enhances transparency by establishing web site disclosure requirements for health insurers for certain rate increases. In addition, in conjunction with promulgating these rules, the Department will provide access from its web site to the Parts I and II of the preliminary justification described in R20-6-2302(A) and will provide on its web site, a mechanism for receiving public comment on proposed rate increases. The Department has posted a rate increase FAQ on its web site and is implementing an educational program called the "Rate Detective." Regarding authority to reject unreasonable rate increases, the Department does not have the statutory authority to disapprove individual rate increases. The federal regulations after which this rulemaking is closely modeled do not give the federal government authority to disapprove or approve individual rate increases. Obtaining such authority for the Department is beyond the scope of this rulemaking.
The commenter requests that ADOI offer more information to the public for public benefit. Allowing individuals to make judgments about the quality and cost of their care will improve their ability to find appropriate services.	The Department agrees that consumers need better information. With regard to transparency that relates to the scope of these rules, the rules will provide for transparency and information as previously discussed. Information regarding the quality of care and finding appropriate services is beyond the scope and authority of this rulemaking.
Requests that a short narrative accompany the information, provided in laymen terms, including: • reasons for the rate increase • impact of the rate increase on the public • details of the anticipated medical trend, level of administrative spending and profit margin, and the data and methodology.	This rulemaking does require a narrative. Every rate increase to which this rulemaking applies must include a preliminary justification that includes: An explanation of the most significant factors causing the rate increase, i.e., the "reason for the rate increase." R20-6-2302(A)(2)(a) Per enrollee per month allocation of projected premium, i.e. "information on the expected impact of the rate on consumers." R20-6-2302(A)(1)(e). Disclosure requirements that collectively include data and methodology. R20-6-2302(A). Trend projections related to utilization, and service or unit cost, i.e. "anticipated medical trend". R20-6-2302(A)(1)(b). The federal regulations upon which this rulemaking is closely modeled do not require insurers to disclose the level of administrative spending. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulation. However, the rulemaking does require disclosure of the impact of non-claims costs on the rate increase. R20-6-2302(A)(1)(d) and R20-6-2302(A)(2)(a). The federal regulation upon which this rulemaking is closely modeled does not require insurers to disclose the profit margin. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulations.

Request that the public is informed of any rate increases that have been deemed unjustified.	The Department is considering appropriate, cost effective methods to notify interested consumers and the general public when it determines that a rate increase is unreasonable.
Request that the Department post all rate increase information on a prominent and easy-to-use web site in order for consumers to easily research rate filings and request that ADOI develop an easy method for the public to comment on rate significant rate filings.	While not a part of this rulemaking, the Department is considering appropriate, cost effective methods to notify interested consumers and the general public about rate increase requests. This might include web site postings.
Consumers Union form letters	
Arizona has a real opportunity right now to help residents with skyrocketing health insurance rates by setting meaningful rules when it comes to reviewing proposed rate increases. I urge you to make rate review in Arizona an open, public and fair process so consumers and insurance companies are heard equally on rate hikes.	The Department takes its regulatory responsibilities very seriously and believes that promulgating these rules is in the best interests of consumers, the industry and the state, and that the rules will provide transparency and information, as previously discussed.
A company's proposed rate, including the entire filing and supporting documents, should be posted on the Arizona Department of Insurance web site, regardless of the amount of the rate hike.	The Department is considering appropriate, cost effective methods to notify interested consumers and the general public about rate increase requests. This may include web site postings.
Policyholders should be notified if the state decides the rate is unreasonable.	The Department is considering appropriate, cost effective methods to notify interested consumers and the general public when it determines that a rate increase is unreasonable.
Consumers should get to comment on proposed rates before they become effective. The Department should notify consumers of their right to comment and publish consumer comments on the Arizona Department of Insurance web site.	While it will not be a part of the rules, the Department is considering the method by which it will provide a mechanism for receiving public comment on proposed rate increases.
The company requesting the rate should document the need for a rate hike and show that the rate hike is supported by substantial evidence. This information should be posted on the Arizona Department of Insurance web site.	This rulemaking does require the insurer to document the need for a rate hike. R20-6-2302, R20-6-2304(3) and R20-6-2305 adopt the federal requirements. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulations. However, the Department provides access from its web site to the preliminary justification included in rate reviews subject to this Article. The Department is considering appropriate, cost effective methods to notify interested consumers and the general public about rate increase requests. This may include web site postings.
The Department should have the authority to ask for more data from a company when it is needed to determine a rate hike's necessity.	The rule requires insurers to provide "[o]ther relevant documentation at the discretion of the Director." R20-6-2305(B)(13).
Additional comments in Consumers Union form letters	
Birmingham	
The commenter requested single pay, regulated healthcare on the national level.	This rulemaking applies to regulatory review of rate increases for individual major medical health insurance. Single pay, regulated healthcare on the national level is beyond the scope of this rule.
Guenter	

The commenter stated that he spends almost 1/3 of retirement income on supplemental health insurance and prescription drugs.	This rulemaking applies to regulatory review of rate increases for individual major medical health insurance. Rates for Medicare coverage are beyond the scope of this rule.
Castro	
Small business owner initially joined NFIB, because of health insurance opportunities but had to drop the insurance coverage in 2010 because, with only two employees, the rates skyrocketed. Commenter dropped own because of pre-existing conditions, and has not had insurance since. Those increases were never justified.	This rulemaking applies to regulatory review of rate increases for individual major medical health insurance. Rate increases for small group insurance are beyond the scope of this rule. With regard to rates for individual insurance, this rulemaking will provide for more disclosure of information regarding rate increases.
Elliot	
Commenter's rates went up 15% again this year (after 15% LY) and that is with reduced benefits AND employer putting in all they can afford. The commenter asks the Department to adopt these important rules when it comes to reviewing any insurer's rates	This rulemaking applies to regulatory review of rate increases for individual major medical health insurance. Rate increases for employer-based health insurance are beyond the scope and authority of these rules.
Bauder	
The commenter is a primary care physician with concerns that insurance companies "run riot" with money designated for the care of Arizona citizens.	These comments refer to Medicaid health plans in Arizona that are regulated by a different state agency, (the Arizona Health Care Cost Containment System or AHCCCS). The Department has no jurisdiction over these health plans and anything relating to them is outside the scope and authority of these rules.
Wilborn	
My families, and many of my neighbors and friends, are having difficulty paying for health insurance. Our current COBRA coverage will expire soon, and I am very concerned about obtaining a replacement policy we can afford.	Establishing or assuring the affordability of individual health insurance is outside the scope and authority of these rules.
Paty	
I don't know if my health insurer will owe me a refund. It is a Medicare Complete policy. Time will tell. Also I don't know if health insurers are required to furnish a financial report to policy holders. If there is not a requirement, there should be.	The federal regulations involved here do not include requirements relating to refunds to consumers or furnishing financial reports to policy holders and such requirements are beyond the scope of the rule. The Department does not have the statutory authority to exceed the requirements of the corresponding federal regulation.
Bergman	
Commenter stated that she has paid high rates for insurance for employees even though they have never had any major health issues and requests the medical insurance companies be better regulated and a regulation on how much they can charge the employers.	This rulemaking applies regulatory review of rate increases for individual major medical health insurance. Matters regarding rate increases for employer-based health insurance are outside the scope and authority of these rules.
George	

I think each insurance company should only be allowed to have one "pool" of insureds. Currently, the have multiple pools that get shut down to new enrollees causing rate hikes in the now shut down pool because healthier people can go find cheaper pools but others with pre-existing conditions cannot (and the pre existing conditions can be a small thing) It would be more fair to the whole insured to have one pool. Of course, the companies would just make more companies to have multiple pools so I would think that a shareholder could not be more than a certain percentage shareholder in another company to stop that 'loophole'.	This rulemaking applies to regulatory review of rate increases for individual major medical health insurance. Matters regarding rate increases for employer-based health insurance and regulation of health insurer risk pools are outside of the scope and authority of these rules.
Davis	
The commenter is a retired state employee and expressed appreciation that she can keep her daughter with a pre-existing condition on her coverage. The commenter states that a large portion of her monthly income goes to health insurance premiums.	These rules apply to individual major medical health insurance. Rate increases for employer-based retirement health coverage health insurance are outside the scope and authority of these rules.
Rider	
The commenter is an employer with health insurance through the Arizona Small Business Association is concerned about a 44% increase in premiums and her insurer's delay in authorizing CT scans.	These rules apply to individual major medical health insurance. Rate increases for small group insurance and matters regarding approval of medical treatment are beyond the scope and authority of these rules.
Fitch	
The commenter expressed concerns about health care costs for the past 2-3 years and the insurance companies not paying or making payment or tracking of services impossible.	It is unclear whether this comment relates to individual health insurance or employer-based health insurance. In any case, establishing or assuring the affordability and administrative efficiency of individual health insurance is beyond the scope and authority of these rules.
Ogrosky	
The commenter expressed concern that the insurance industry has never been regulated in this state and that consumers are being gouged.	The Department takes its regulatory responsibilities very seriously and believes that promulgating these rules is in the best interests of consumers, the industry and the state, and that the rules will provide transparency and useful information, as previously discussed.
McCarthy	
The commenter expressed concern about a 35% increase her insurance rate (effective May 1) and with insurance company policies.	Neither state nor federal law gives the Department authority to limit rate increases. With regard to transparency that relates to the scope of these rules, the rules will provide transparency and information as previously discussed.
Yoshino	
I ask that insurance companies be held to the affordable health care laws and that 80% of our premiums go to actual health care and no more than 20% be spent on health care administration and company profits.	Requirements relating to the percentage of premiums that health insurers spend on health care expenses versus administrative expenses or profit are beyond the scope and authority of these rules.
Koenig	
The commenter stated that If the insurance company policies are above-board, then they should not worry about letting someone know what they are doing with the money.	Requirements relating to how health insurers spend premiums are beyond the scope and authority of these rules.

Whitaker	
The commenter stated that Arizona is watching and urged the Department think of the people and not the insurance industry and their unending goal of trying to cheat people insured in Arizona.	The Department takes its regulatory responsibilities very seriously and believes that promulgating this rule is in the best interests of consumers, the industry and the state, and that the rules will provide transparency and useful information, as previously discussed.
Cole	
I and many others invest substantial amounts of money in insurance premiums in an effort to take personal responsibility for our own health care. Please help us by using these reasonable ways to control rates.	The Department takes its regulatory responsibilities very seriously and believes that promulgating this rule is in the best interests of consumers, the industry and the state, and that the rules will provide transparency and useful information, as previously discussed.
Heath	
You may not like the law, but you have a fiduciary responsibility to the citizens of AZ to hold insurers' feet to the fire about the outrageous increases in premiums so they can get the most money from consumers while they can	The Department takes its regulatory responsibilities very seriously and believes that promulgating this rule is in the best interests of consumers, the industry and the state.
Brink	
I have worked hard all my life to have a safe and secure retirement but the terrible economy crushed my 401k and huge healthcare costs may force us out of our home. Help us please!	The Department appreciates the difficult economic times in which many Arizonans find themselves. However, neither state nor federal law gives the Department authority to limit rate increases. But, with regard to transparency that relates to the scope of these rules, the rules will provide transparency and useful information as previously discussed.
Acosta	
PLEASE use the resources at your disposal to keep the Insurance Companies “in-check” and protect us consumers from being taken advantage of!	The Department takes its regulatory responsibilities very seriously and believes that promulgating this rule is in the best interests of consumers, the industry and the state.
Allison	
Insurance companies should not even be in the medical field there are plenty of other things for them to insure and If they are overcharging they should have to pay it back	Matters relating to whether insurance companies should be in the medical field, or paying back charges, are beyond the scope and authority of these rules.
Green	
You are our defense against those who hold inordinate power due to the business they are in. We are counting on you...	The Department takes its regulatory responsibilities very seriously and believes that promulgating this rule is in the best interests of consumers, the industry and the state.
Sadi	
Remember, you have an opportunity to be part of the solution. Inactivity, makes you part of the problem and that becomes public information which will haunt you.	The Department takes its regulatory responsibilities very seriously and believes that promulgating this rule is in the best interests of consumers, the industry and the state.
Omlor	

I want my insurance company to make public the amount it wants to raise rates each year, and to publicly justify why it needs a big rate hike.	This rulemaking sets disclosure and justification requirements for individual health insurance rate increases of 10% or more. See R20-6-2302. To enhance the transparency regarding rate increases, the Department will provide access from its web site to this information and will provide on its web site a mechanism for receiving public comment on proposed rate increases.
Dr. Margaret Johnson – Scottsdale	
It's time for the insurance companies to stop gauging the American public. They deserve to make a profit, but not an exorbitant one.	This rulemaking applies to regulatory review of rate increases for individual major medical health insurance. Matters regarding health insurer profits are beyond the scope and authority of these rules.
Winslow	
All of the above suggestions would greatly improve health insurance coverage in Arizona. There is no reason not to do this.	The Department has given careful consideration to all the comments it received and is moving forward with finalizing this rulemaking.
Trina	
The Department should notify consumers of their right to comment and publish consumer comments on the Arizona Department of Insurance web site.	The Department is considering appropriate, cost effective methods to notify interested consumers and the general public when it receives rate increase requests. The Department will provide on its web site a mechanism for receiving public comment on proposed rate increases.
Ratazzo	
Information about why insurance premiums increase, even though the insurance was not used, should be posted on the Department web site.	The Department agrees that greater transparency regarding rate increases would benefit consumers. In conjunction with promulgating these rules, the Department will provide a link from its web site to the federal web site that contains the Parts I and II of the preliminary justification described in R20-6-2302(A). The Department will also provide on its web site a mechanism for receiving public comment on proposed rate increases. The Department has posted on its web site a rate increase FAQ and will post an online educational program called the Rate Detective.
Overturf	
Access to needed information: The Arizona Department of Insurance should have the authority to ask for more data from a company when it is needed to determine a rate hike's necessity. This is especially true for people like me who are older than 70 and having to depend on their FEHB health insurance. The AETNA people raised last January over $230 a month from previous year for me and my spouse just because we live in Maricopa county...no explanation or anything.	These rules apply to regulatory review of rate increases for individual major medical health insurance. Rate increases for employer-based health insurance are beyond the scope and authority of these rules. However, R20-6-2305(B)(13) does require that insurers provide "[o]ther relevant documentation at the discretion of the Director."
Brubaker	

Offer benchmarking summary information that would allow consumers to compare one company's plan and cost against most others at the AZ Department of Insurance site. To make this meaningful, there ought to be at least one state-defined "Standard Plan" with a fixed set of clearly defined basic benefits that every insurer operating in the state must offer. Then bundle blocks of additional coverage features to allow insurers to offer comparable "Premium" plans. Then consumers could make meaningful comparisons. Use Oregon's Cost vs. Effectiveness list to choose which diagnostic and treatment features get offered at each level. Think of this bundling process like "trim levels" that Japanese car makers used to streamline auto production.	The Department agrees that increased transparency would benefit consumers. In conjunction with promulgating these rules, the Department will provide access from its web site to the Parts I and II of the preliminary justification described in R20-6-2302(A) and will provide on its web site a mechanism for receiving public comment on proposed rate increases. The Department has posted a rate increase FAQ on its web site and is implementing an online educational program called the Rate Detective. However, plan comparisons, a state-defined standard plan, plan selection options and materials and other information, as described in this comment, are beyond the scope and authority of these rules.
Jaffe	
The commenter supports state review of any insurance carrier that proposes to increase rates by any amount, not just the 10% proposed. If the amount is set at 10%, insurance companies will just raise rates 9.9% repeatedly. The medical insurance companies need regulation.	The Department is required to make rules that are consistent with the corresponding statutory authority, which, currently, addresses rates increases above 10%.
Boroson	
Comments that she enrolled in Medigap insurance, Plan F, at the beginning of 2010. Her company insurance, provided to retirees, was discontinued, so she was guaranteed issue. Her initial premium was $369/quarter. The most recent bill she received is $638/quarter, an over 70% increase. The rate was changed three times in this two-year period She is unable to change to another company or plan because preexisting conditions would result in even higher rates or denial. She requests legislation to prevent the high cost of Medigap insurance.	Issues regarding Medigap are out of the purview of this rulemaking. A decision regarding legislation must come from the legislature, rather than the Department.
Esparza	
I checked into the Arizona state health plan for myself and learned that the monthly bill would be $561.00 per month. This is outrageous and sad for a public servant to pay a month. I worked 32 years for the State of Arizona and this is my reward. Health plan monthly bills need to be more reasonable and not be an avenue for health plans to made *(sic)* tremendous profits.	The Department appreciates the concern with the cost of health insurance premiums. The Department does not have authority to limit a company's profits and can only act within the scope of authority in statute and rule.
Kavanagh	
Commenter stated that a percentage of an insured's bill that is added due to the uninsured and underinsured's inability to pay should be given to pay for health care costs.	This would be outside the scope of authority for these rules.
Severson	

More transparency and enhanced consumer protections could allow for a more competitive insurance marketplace, resulting in lower health insurance costs and improved coverage.	The Department expects that this rulemaking will enhance transparency and consumers will have new tools to use to be informed regarding rate review for individual insurance. Issues regarding competitiveness in the marketplace and lowering health insurance costs are outside the purview of this rulemaking.
Facio	
Comments that ADOI approved an excessive long term care increase.	Long-term care insurance is outside the purview of this rulemaking.
Triesky	
Commenter employs less than 10 employees. She would like to know why her Blue Cross Blue Shield of Arizona insurance is allowed to increase rates approximately 50% per year. The commenter pays 80% of the monthly amount and the employee pays 20%. She just received rates for renewal beginning August 1, 2012, and has another 50%. Requests suggestions as to how to continue to provide coverage for employees and keep the rates at a reasonable level.	Small group health insurance is outside the purview of this rulemaking. The Department does expect to promulgate a rulemaking regarding small group health insurance in the near future.
Retallick	
The commenter states that she received two rate hike notices in less than a year. She thinks that future Health Markets rate hikes should be examined very closely in light of a lawsuit by the City of Los Angeles against the company and barring by the Commonwealth of Massachusetts from selling policies there.	The Department cannot address matters regarding other jurisdictions that are unrelated to this rulemaking. The Department believes that requirements in these rules will increase transparency, as previously discussed. All rate hikes will be given the appropriate scrutiny as provided for by law, regardless of what company is involved.
McCabe	
Something has got to be done to stop health insurance providers from increasing premiums on people who are healthy. Health insurance providers should not be allowed to spend members premiums for sponsoring plays, closed captioning, advertising, excessive salaries for CEO's corporate officers or political donations.	The Department appreciates the concern with the cost of health insurance premiums. The Department expects that this rulemaking will enhance transparency and consumers will have new tools to use to be informed regarding rate review for individual health insurance. The Department does not have authority to determine how a company spends on these matters and can only act within the scope of authority in statute and rule.
Olmstead (AzPHA)	
Such a change (prior approval) may require changes in statutes and rules. Over thirty other states already have prior approval authority for at least some insurance products, including other western states like New Mexico, Nevada and Colorado.	A change in statutes will have to come from the legislature. What is included in these rules cannot be based on what has happened in other states, but is determined by the statutory authority that the Department has for this rulemaking. The Department does not have authority to include prior approval in these rules.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

Not applicable

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal

law and if so, citation to the statutory authority to exceed the requirements of federal law:
A federal law is applicable. The rule is not more stringent than federal law.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:
Not applicable.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:
Not applicable

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:
No

15. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 23. THRESHOLD RATE REVIEW – INDIVIDUAL HEALTH INSURANCE

Section

ARTICLE 23. THRESHOLD RATE REVIEW – INDIVIDUAL HEALTH INSURANCE

R20-6-2301. Applicability; Definitions

A. This Article applies to rates charged by health insurers for individual health insurance. This Article does not apply to rates charged by health insurers for the following:

1. Health insurance that a health insurer issues to an employer or to any group described in either A.R.S. § 20-1401 or A.R.S. § 20-1404(A), except health insurance issued to an association or its individual members as described in R20-6-2301(B)(7)(b);
2. Grandfathered health plan coverage as defined in 45 CFR 147.140; or
3. Health insurance that covers excepted benefits as described in section 2791(c) of the PHS Act, 42 U.S.C. 300gg-91(c).

B. In this Article, the following definitions apply:

1. "Department" means the Arizona Department of Insurance.
2. "Blanket disability insurance" has the meaning prescribed in A.R.S. § 20-1404(A).
3. "CMS" means the Centers for Medicare & Medicaid Services.
4. "Federal medical loss ratio standard" means the applicable medical loss ratio standard determined under 45 CFR 158, Subpart B.
5. "Health insurance" means disability insurance as defined in A.R.S. § 20-253, a health care plan as defined in A.R.S. § 20-1051(5) and disability insurance or a health care plan offered by a hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation as defined in A.R.S. § 20-822(3).
6. "Health insurer" means an insurer, as that term is defined in A.R.S. § 20-104, authorized to transact disability insurance in Arizona, a health care services organization as defined in A.R.S. § 20-1051(7) or a hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation as defined in A.R.S. § 20-822(3).
7. "Individual health insurance" means health insurance that a health insurer issues to either:
   a. An individual, to cover:
      i. The individual, or
      ii. The individual's dependents, or

iii. The individual and the individual's dependents.

b. An association or its individual members to cover the individual members and their dependents, and which the Department would regulate under A.R.S. Title 20, Chapter 6 as individual health insurance if the health insurer did not issue it to an association or individual members of an association.

8. "PHS Act" means Part A of Title XXVII of the Public Health Service Act, 42 U.S.C. Chapter 6A.
9. "Product" means a package of health insurance benefits with a discrete set of rating and pricing methodologies that a health insurer offers as individual insurance in Arizona.
10. "Preliminary justification" means a justification that consists of the parts described in R20-6-2302(A).
11. "Rate increase" means an increase of the rates for an individual health insurance product that a health insurer offers in Arizona that:
    a. Results from a change to the underlying rate structure of the product, and
    b. May result in premium changes for the product.
12. "Secretary" means the Secretary of the United States Department of Health and Human Services.
13. "Threshold rate increase" means a rate increase that meets or exceeds an Arizona-specific threshold as noticed by the Secretary in 45 CFR 154.200, provided:
    a. The average increase for all enrollees weighted by premium volume meets or exceeds the applicable threshold; and
    b. If a rate increase that does not otherwise meet or exceed the Arizona-specific threshold meets or exceeds the Arizona-specific threshold when combined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to meet or exceed the Arizona-specific threshold and is subject to threshold rate review that shall include a review of the aggregate rate increases during the applicable 12-month period.
14. "Threshold rate review" means the review by the Department under this Article of a threshold rate increase.
15. "Unreasonable rate increase" means a rate increase that results in benefits that are not reasonable in relation to the premium the health insurer charges for the product. The following factors are relevant in determining whether a rate increase results in benefits that are unreasonable in relation to premium:
    a. The rate increase results in a projected medical loss ratio below the federal medical loss ratio standard after accounting for any adjustments allowable under federal law;
    b. One or more of the assumptions on which the health insurer based the rate increase is not supported by sound actuarial reasoning, data and analysis;
    c. The choice of assumptions or combination of assumptions on which the insurer based the rate increase is unreasonable;
    d. The health issuer provides data or documentation that is incomplete, inadequate or otherwise does not provide a basis upon which the Department can determine the reasonableness of a rate increase; or
    e. The increase results in premium differences between insureds within similar risk categories that are unfairly discriminatory under A.R.S. Title 20, Chapter 2, Article 6.

R20-6-2302. Disclosure of Preliminary Justification

A. Preliminary Justification. For each threshold rate increase for each affected product, a health insurer shall submit to the Department and to CMS, on a form and in the manner prescribed by the Secretary in 45 CFR 154.215, a preliminary justification that contains all of the following:
1. Preliminary Justification Part I. A summary of the content of the threshold rate increase that includes:
    a. Historical and projected claims experience;
    b. Trend projections related to utilization, and service or unit cost;
    c. Any claims assumptions related to benefit changes;
    d. Allocation of the overall rate increase to claims and non-claims costs;
    e. Per enrollee per month allocation of current and projected premium; and
    f. Three year history of rate increases for the product associated with the rate increase.
2. Preliminary Justification Part II. A written description that justifies the rate increase and that contains a simple and brief narrative describing the data and assumptions the health insurer used to develop the rate increase, and includes the following:
    a. An explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in subsection (A)(1); and
    b. A brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.

B. A health insurer may submit a single, combined preliminary justification that contains all the information in subsections (A)(1) and (2) for threshold rate increases that affect more than one product if the health insurer has aggregated the claims experience of all products to calculate the rate increases and the rate increases are the same for all products.

R20-6-2303. Timing for Submission of Preliminary Justification

A. If R20-6-607 applies to a threshold rate increase, the health insurer shall submit its preliminary justification to the Department and to CMS on the date on which the health insurer files the rate increase request under R20-6-607.

B. If R20-6-607 does not apply to a threshold rate increase, the health insurer shall submit the preliminary justification to the Department and to CMS at least 60 days prior to the date the health insurer intends to implement the threshold rate increase in Arizona.

C. The Department shall provide access from its website to the Parts I and II of the Preliminary Justifications of the proposed rate increases that it reviews and have a mechanism for receiving public comments on those proposed rate increases.

R20-6-2304. Response to Unreasonableness Determination

If the health insurer receives from CMS a notice that the Department has determined that the health insurer's threshold rate increase is unreasonable, the health insurer shall select one of the following three options:

1. Option to not implement the rate increase determined unreasonable. Within 30 days of receiving from CMS the Department's determination, the health insurer shall notify the Department and CMS that it will not implement the rate increase and request the Department to withdraw the rate increase request;
2. Option to implement a smaller rate increase than the rate determined unreasonable. Within 30 days of receiving from CMS the Department's determination, the health insurer shall notify the Department and CMS, on a form and in the manner prescribed by the Secretary, that it intends to implement a rate increase that is smaller than the one determined unreasonable. One of the following shall apply to this option:
   a. If the health insurer selects this option and the smaller rate increase is not a threshold rate increase, the smaller rate increase is not subject to this Article;
   b. If the health insurer selects this option, and R20-6-607 applied to the rate increase the Department determined to be unreasonable, the health insurer shall revise the rate increase filing to reflect the smaller rate increase or file a new rate increase. If the smaller rate increase is a threshold rate increase, the health insurer shall submit a new preliminary justification on the date the health insurer revises the rate increase filing or files a new rate increase; or
   c. If the health insurer selects this option, and R20-6-607 did not apply to the rate increase the Department determined to be unreasonable, and the smaller increase is a threshold rate increase, the health insurer shall submit to the Department and to CMS a new preliminary justification at least 60 days prior to the date the health insurer intends to implement the smaller increase in Arizona.
3. Option to implement the rate increase determined unreasonable. Within 10 business days after the health insurer either implements the rate increase that the Department determined unreasonable, or receives from CMS the Department's determination, the health insurer shall:
   a. Submit, to the Department and to CMS, a final justification in response to the Department's determination. The information in the final justification shall be the same as the information submitted by the insurer under R20-6-2302(A)(1) and (2) in the preliminary justification supporting the rate increase; and
   b. Prominently post on its website, on a form and in the manner prescribed by the Secretary under 45 CFR 154.230 the following information:
      i. The Department's determination that the rate increase is unreasonable and Department's explanation of the Department's analysis of the relevant factors set forth in R20-6-2305(A)(1) and (2), and
      ii. The health insurer's final justification for implementing the rate increase.
   c. Continue to make the information in subsection (3)(b) available to the public on its website for at least three years.

R20-6-2305. Threshold Rate Increase Documentation Requirements

A. For a threshold rate increase, a health insurer shall submit to the Department documentation that is sufficient to allow the Department to assess:
1. The reasonableness of the assumptions used by the health insurer to develop the proposed rate increase and the validity of the historical data underlying the assumptions, and
2. The health insurer's data related to past projections and actual experience.

B. To the extent applicable to the submission under review by the Department, the health insurer shall submit documentation that includes all of the following:
1. The impact of medical trend changes by major service categories;
2. The impact of utilization changes by major service categories;
3. The impact of cost-sharing changes by major service categories;
4. The impact of benefit changes;
5. The impact of changes in enrollee risk profile;
6. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
7. The impact of changes in reserve needs;
8. The impact of changes in administrative costs related to programs that improve health care quality;

9. The impact of changes in other administrative costs;
10. The impact of changes in applicable taxes, licensing or regulatory fees;
11. Medical loss ratio;
12. The health insurance insurer's capital and surplus; and
13. Other relevant documentation at the discretion of the Director.

C. A health insurer shall submit all documentation required under subsection (A) or (B) at the same time that:

1. The health insurer submits the preliminary justification required under R20-6-2302, or
2. The health insurer submits any new preliminary justification required under R20-6-2304(2)(b) and (c).